

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2011
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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN47586
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint # IN00098222.</p> <p>Complaint # IN00098222- Substantiated. Federal/state deficiencies related to allegations are cited at F364, F365, and F242.</p> <p>Survey dates: October 30, 31, November 1, 2, 3, 4, 7, 9, 2011</p> <p>Facility Number: 002512 Provider Number: 155671 AIM Number: 200278690</p> <p>Survey Team: Carole McDaniel RN TC Martha Saul RN October 30, 31, November 1, 2, 3, 4, 7, 2011 Terri Walters RN October 31, November 1, 2, 3, 4, 7, 9, 2011</p> <p>Census Bed Type: SNF: 28 SNF/NF: 60 Residential: 20 Total: 108</p> <p>Census Payor Type: Medicare: 24</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Medicaid: 43 Other: 41 Total: 108</p> <p>Stage 2 sample: 20 Residential sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/16/11 Cathy Emswiller RN</p>				

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F0164 SS=D	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on interview, record review, and interview, the facility failed to ensure privacy during a respiratory treatment for 1 of 2 residents observed receiving respiratory treatments during medication pass. Resident #78</p> <p>Resident #78's clinical record was reviewed on 11/3/11 at 2:15 P.M. His current November 2011 physician orders</p>	F0164	Resident #78 suffered no ill effects from the alleged deficient practice and through corrective action and inservicing will ensure resident's privacy is maintained. All residents have the potential to be affected and therefore through aeration in provision of meds and inservicing will ensure that privacy is maintained. Systemic change to ensure privacy is maintained during breathing treatments is to have the door shut or room curtain	12/09/2011

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	<p>included but were not limited to: Albuterol .083% (.83 mg/ml) solution -use 1 unit dose per MN (mini nebulizer) TX (treatment) every 4 hours while awake.</p> <p>On 11/3/11 at 2:00 P.M., LPN #2 administered the breathing treatment of the medication Albuterol to Resident #78. Resident #78 was in bed in his room with his room door open to the hall. His bed was the closest bed to the room door and hall area. His roommate was present in the room and the privacy curtain was not pulled between the 2 residents or the hall area during the treatment.</p> <p>The breathing treatment was completed on 11/3/11 at 2:10 P.M. The room door of Resident #78 remained open thru out the treatment with random staff and residents passing by Resident #78's room.</p> <p>On 11/9/11 at 10:00 A.M., the Director of Nursing was made aware of the lack of privacy during the breathing treatment of Resident #75 on 11/3/11 at 2:00 P.M. The DON indicated she was aware of the lack of privacy of this treatment due to she had observed LPN #2 come out of the room and the door being open during the treatment.</p>		<p>pulled around the resident and staff will be inserviced on interpretive guidelines as it relates to privacy.DHS or designee will audit one random resident receiving breathing treatments 1X/day for 2 weeks, then 2X weekly for 2 months, 2/month thereafter with results of audits being submitted to QA committee monthly for 6 months and quarterly thereafter.</p>		

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F0167 SS=B	<p>3.1-3(o)</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview the facility failed to post State survey results in an accessible manner on 7 of 8 survey days. This had the potential to impact 88 residents.</p> <p>Findings include:</p> <p>On entry to the building foyer on 10/30/11 at 4:50 P.M., the survey was observed to be in a standard manual, located on a counter shelf under the business office window. It was located was above wheel chair level and appeared to be facility materials stored on the shelf without clear designation, as being survey results, visible. Wheel chair resident would</p>	F0167	There were no residents affected be this deficient practice and none that were potentially affected. Administrator inserved on requirements of the displaying of survey results. Posting will be accessible at w/c height and clearly designated on binder as survey results in large font, located in the lobby of the main entrance. QA rounds monthly will include verification that the survey results are posted and in required format X 12 months.	12/09/2011	

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F0176 SS=D	<p>have to reach above shoulder level and lift the book down, if able, in order to obtain the results.</p> <p>On 10/31,11/1, 11/2, 11/3, 11/4,11/7/2011 at 9:00 A.M. observations, the survey was posted in the exact non accessible position.</p> <p>On 11/7/11 at 1:00 P.M., the Administrator was interviewed regarding the posting and she indicated she would ensure the survey was posted for accessibility to wheel chair residents.</p> <p>3.1-3(b)(1)</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was not assessed to administer his own medication did not administer his own medications for 1 of 11 residents observed for medication pass. Resident #6</p> <p>Findings include:</p> <p>Resident #6's clinical record was reviewed on 11/7/11 at 7:50 A.M. His current</p>	F0176	Resident # 6 suffered no ill effects from the alegend deficient practice and through corrective action and inservicing will ensure residents that self administer medication have been reviewed by interdisciplinary team and deemed appropriate to do so.All residents that self administer have the potential to be affected and therefore have been assessed by interdisciplinary team to ensure they are safe to do so and through education/inservicing will ensure that residents are reviewed by the	12/09/2011	

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	<p>November 2011 physician orders included but were not limited to: an order initiated 8/30/11, for: "... Miralax powder -mix 17 grams (one lid full) in 8 oz liquid & give orally every day for constipation."</p> <p>Resident #6's November 2011 physician orders lacked documentation of a physician order for self medication administration.</p> <p>On 11/4/11 at 9:55 A.M., LPN #1 prepared Resident #6's morning am oral medications which included the Miralax powder (17 grams) in 8 ounces of water. This Miralax mixture was poured into 2 small plastic glasses. The resident was sitting up in bed and took his oral pills first. The 2 glasses with Miralax were left on the resident's bedside table for the resident to take on his own. As the nurse exited the room, the resident picked up one of the glasses and was just starting to take a drink.</p> <p>On 11/7/11 at 1:15 P.M., the Director of Nursing (DON) was made aware Resident #6's Miralax medication had been left at the bedside for the resident to take his self. The DON indicated at this time that nurses were not to leave medication at the bedside for residents to take on their own. She also indicated the facility had just</p>		<p>team prior to being allowed to do so. Systemic change will include interdisciplinary team and licensed nurses education/in-service on interpretive guidelines as it relates to self administering medication. DHS/Designee will monitor random residents receiving their medication to ensure they are assisted by licensed personnel to consume it. Audit will include 3 random residents daily for 2 weeks, 3 random residents weekly for 2 weeks and then 3 random residents monthly thereafter. DHS/Designee will ensure that residents are not administering their own meds unless assessed by the interdisciplinary team when order is received to do so. Results of audits will be forwarded to QA committee monthly X6 mos. and then quarterly thereafter.</p>		

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F0242 SS=A	<p>had an inservice on medication administration.</p> <p>On 11/7/11 at 2:00 P.M., the DON provided a copy of the nursing inservice (dated 8/19/11 at 2:00 P.M.) which included "Medication Pass Procedures- Error Prevention. This facility inservice included but was not limited to: "...DURING MEDICATION PASS: Monitor resident, make sure medication is taken and Leave NO medications at bedside..."</p> <p>3.1-11(a)</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure that food choices were honored for residents based on 2 out of 3 resident council minutes reviewed for meal choices and 1 confidential family interview regarding food choices and 1 of 8 alert and oriented residents interviewed regarding meal choices.</p> <p>Family Member #1, Resident D</p> <p>Findings included:</p>	F0242	Resident D suffered no ill effects from the alleged deficient practice and through corrective action and inservicing will ensure resident's food choices are honored. All residents have the potential to be affected and therefore through inservicing will ensure that food choices are honored. Systemic change to assure food choices are honored is to have food preferences updated and staff will be inserviced on interpretive guidelines as it relates to resident	12/09/2011

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	<p>1. The resident council minutes from the June 10, 2011 meeting were reviewed. These minutes indicated the following: "...the DSM (Dietary Service Manager) explained selective menus and how residents can choose alternatives..." The August 11, 2011 resident council meeting minutes indicated the following: "When they pick the 2nd option on the next day menu, they still get the regular menu items, would like it double checked for accuracy." A form titled "Resident council Follow up" was dated 8/31/11. This form indicated the following concern was brought to the attention of the Resident council on 8/11/11: "When they pick the 2nd option on the next day menu, they still get the regular menu item. Resident's would like a better system for accuracy, "double checked.?" The dietary response follows on 8/12/11: "Dietary will double check menus to make sure what is ordered will be prepared as ordered."</p> <p>Resident council minutes dated 9/8/11 indicated the following: "...Still not receiving what resident ordered and it was identified that the request in writing (done the day before) is often not attached to the menu selection...One resident receiving items that were clearly marked on personal preference she does not like..."</p>		<p>rights to make choices about food.DFS/Designee to monitor resident meal tickets to assure that the food item selected is served. DFS/Designee to monitor 3 resident meal tickets daily X 2 weeks, 3 resident meal tickets weekly X 2 months, 3 resident meal tickets monthly thereafter. Audits will be submitted to QA committee monthly X 6 months then quarterly thereafter.</p>	

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	<p>The Resident council follow up form, dated 9/9/11 indicated the following: "Cook and dietary aides will both double check for any selections to make sure res (resident) gets what they ordered. Week (sic) start server at breakfast on Saturdays- will monitor schedule with nsg (nursing)."</p> <p>On 10/31/11 at 12:18 P.M., Resident D was interviewed and stated "I can't eat corn, I've told them but they must forget who can have what, so I just don't eat it."</p> <p>On 11/1/11 at 11:17 A.M. a family interview was conducted. Family member #1 indicated "...meals are not always served according to choices..."</p> <p>On 11/3/11 at 1:53 P.M., the Administrator was interviewed. She indicated an inservice was completed for staff regarding the inaccuracy of the meal ticket requests.</p> <p>This Federal tag relates to complaint #IN00098222</p> <p>3.1-3(u)(3)</p>				

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F0281 SS=D	<p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation , interview, and record review, the facility failed to ensure a pressure sore treatment was provided by qualified staff for 1 of 1 resident reviewed for pressure sores who met the criteria for pressure sores. Resident #109</p> <p>Findings include:</p> <p>Resident # 109's clinical record was reviewed on 11/7/11 at 10:20 A.M. Her current Minimum Data Set Assessment (MDS) dated 9/21/11, indicated a cognitive score of 15 (cognition intact), physical assistance of 2 staff for bed mobility, transfers and toileting.</p> <p>Current physician order which was initiated 9/9/11, instructed to cleanse the wound of the coccyx with wound cleanser, pack with calcium alginate and cover with optifoam dressing every day and prn (when needed).</p> <p>A pressure ulcer assessment form initiated on 6/15/11(resident's admission date), indicated a pressure ulcer of the left</p>	F0281	<p>Res 109 suffered no ill effects from the alleged deficient practice and the licensed staff that care for her have been inserviced on her plan of care as it relates to their duties and scope of practice.All residents have the potential to be affected by the staff's deficient practice. With initiation of inservices and practice alteration will ensure qualified individuals perform duties as allwed by scope of practice.QMA's will have indepth inservice related to scope of practice and review of acceptable tasks.DHS/Designee will observe care/dressing changes 3/day for 2 weeks, and 1/weekly thereafter. Compliance with repositioning/scope of practice procedures related to wound care will be observed.Results of audits will be forwarded to QA committee monthly X 6 months and quarterly thereafter.</p>	12/09/2011

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	<p>coccyx stage E ("...Unstageable-Non-removable dressing slough/eschar, suspected deep tissue injury in evolution.)" The measurements of this pressure area were 1.5 cm length x 2 cm with 0 depth.</p> <p>Current pressure sore measurements of the coccyx were documented on 11/2/11, as visualized stage 4 area of 0.8 cm length x 0.8 cm width and a depth of 0.6 cm.</p> <p>Her current care plan with an initiation date of 6/22/11, addressed the problem of alteration in skin integrity related to a pressure sore. Interventions included but were not limited to: pressure reducing mattress to bed, pressure reducing cushion to chair, and turn and reposition q (every) 2 hours and prn (whenever necessary).</p> <p>On 11/3/11 at 10:00 A.M., the RN unit manager for Resident #109, was made aware the Resident #109 was being observed for nursing care. She indicated at this time she would make nursing staff caring for Resident #109 aware of nursing care being observed. At this time 11/3/11 at 10:00 A.M., Resident #109 was observed up in her w/c (main dining room) with an anti pressure cushion in place.</p> <p>On 11/3/11 at 11:12 A.M., Resident #109</p>				

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	<p>remained up in her w/c in the hall by her room doorway. Resident #109 at this time was asked by Qualified Medication Aide(QMA) #1 if she needed to use the bathroom. The resident indicated she did not.</p> <p>On 11/3/11 at 11:40 A.M., during interview with QMA #1, she indicated before 10:00 A.M., today, Resident #109, had a large bm and soilage of her pressure sore dressing. The QMA indicated she had replaced the optimfoam dressing (outer dressing) and told the nurse who would do the complete pressure sore daily treatment including the packing of the wound.</p> <p>On 11/3/11 at 12:15 P.M., Resident #109 remained up in her w/c and was in the main dining room feeding herself lunch.</p> <p>On 11/3/11 at 12:45 P.M., Resident #109 was observed in her w/c, propelling herself back to her room from the main dining room.</p> <p>On 11/3/11 at 1:20 P.M., QMA #1 and CNA#1 assisted Resident #109 to transfer from her w/c to the commode for toileting. After toileting, CNA#1 and QMA #1, assisted Resident #109 to bed and Unit Manager RN #1 began coccyx pressure sore treatment. Unit Manager</p>			

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	<p>RN#1, then removed the old dressing, cleansed the pressure sore, packed the wound and applied the opti foam dressing as ordered. The open coccyx pressure area had clean defined edges without redness. This open area was approximately the size of a pencil eraser.</p> <p>On 11/9/11 at 9:55 A.M., the Director of Nursing (DON) and the MDS nurse were made aware of Resident #109 without position change from 10:00 A.M., on 11/3/11 to 1:20 P.M. The DON and MDS nurse were also made aware at this time that the complete treatment for the coccyx pressure sore was not completed by the nurse after the QMA initiated dressing change without packing of the ulcer before 10:00 A.M., on 11/3/11.</p> <p>QMA Performance Checklist on the ISDH (Indiana State Department of Health) web site Lesson 56, 1. H.3. addressed Decubitus ulcer (Pressure Sores). This information included but was not limited to: "... The treatment of a decubitus ulcer greater than a Stage 1 is not within the QMA scope of practice..."</p> <p>3.1-35(g)(1)</p>				

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications which were not to be crushed were administered without crushing for 1 of 2 residents observed who had received crushed medications during medication pass of 11 residents. Resident #1</p> <p>Findings include:</p> <p>On 11/4/11 at 9:34 A.M., LPN #1 had begun preparation of Resident #1's morning oral medications. The am medications to be given were as followed: Aspirin 81 mg EC (enteric coated), Plavix 75 mg, Keppra 250 mg, Lasix 40 mg, and Colace. LPN #1 indicated she would crush all Resident #1's am medications except the Colace (gel filled capsule) and administer in applesauce. All am medications were crushed except the Colace and were given in applesauce.</p> <p>A facility document entitled,"MEDICATIONS NOT TO BE CRUSHED" was received and reviewed</p>	F0282	<p>Res #1 medication orders and MAR's reviewed with licensed staff that pass medication. There were no other residents affected be the deficient practice and through MAR changes and inservicing will ensure meds that are not intended to be crushed will not be unless ordered specifically to do so by MD. Systemic change will be adding "Do Not Crush" at the bottom of med entry on the MAR for those meds deemed not crushable by pharmacy standards. Nursing staff will be inserviced on new MAR update and the "Do not crush" list that is provided in the MAR. DHS/Designee will monitor 2 random do not crush meds daily for 2 weeks, then 2 weekly X 12 weeks and 2 random monthly thereafter for accurate delivery of meds. Audits will be forwarded to QA committee monthly for 6 months and quarterly thereafter.</p>	12/09/2011

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	<p>on 11/7/11 at 7:45 A.M. This document included the drug Aspirin (enteric coated) was not to be crushed.</p> <p>On 11/7/11 at 1:10 P.M., the Director of Nursing (DON) was made aware of Resident #1's enteric coated aspirin being crushed and administered during med pass on 11/4/11. She indicated at this time the enteric coated should not be crushed. The resident's medication card containing the enteric coated aspirin was observed at this time and included the instructions, "DO NOT CRUSH."</p> <p>The 2010 Nursing Spectrum Drug Handbook on page S11 under the chapter "Safe drug administration", included but was not limited to: "Crushing extended-release or other long -acting oral drug forms can cause the ingredients to be released all at once instead of gradually. Similarly, crushing can break the coating of the enteric-coated drugs, leading to GI (gastric-intestinal) irritation..."</p> <p>3.1-35(g)(2)</p>				

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F0314 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation , interview, and record review, the facility failed to ensure pressure sore treatments and position changes were timely for 1 of 1 resident reviewed for pressure sores who met the criteria for pressure sores. Resident #109</p> <p>Findings include:</p> <p>Resident # 109's clinical record was reviewed on 11/7/11 at 10:20 A.M. Her current Minimum Data Set Assessment (MDS) dated 9/21/11, indicated a cognitive score of 15 (cognition intact), physical assistance of 2 staff for bed mobility, transfers and toileting.</p> <p>Current physician order which was initiated 9/9/11, instructed to cleanse the wound of the coccyx with wound cleanser, pack with calcium alginate and cover with optifoam dressing every day and prn (when needed).</p> <p>A pressure ulcer assessment form initiated</p>	F0314	Res 109 suffered no ill effects from the aleged deficient practice and the licensed staff that care for her have been inserviced on her plan of care as it relates to their duties and scope of practice.All nursing staff that care for resident 109 have been inserviced on repositioning and pressure ulcer treatment orders.All residents have the potential to be affected by the staff's deficient practice. With initiation of services and practice aleration will ensure residents with pressure ulcers receive treatments and position changes timely.QMA's will have in depth inservice related to scope of practice and review of acceptable tasks.DHS/Designee will observe positioning and care/dressing changes of 3 residents/day for 2 weeks, 3 residents/week for 2 weeks and 1 resident weekly thereafter. Compliance with repositioning/dressing change procedures related to pressure ulcers will be observed.Results of audits will be forwarded to QA committee monthly X 6 months	12/09/2011

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	<p>on 6/15/11(resident's admission date), indicated a pressure ulcer of the left coccyx stage E ("...Unstageable-Non-removable dressing slough/eschar, suspected deep tissue injury in evolution.)" The measurements of this pressure area were 1.5 cm length x 2 cm with 0 depth.</p> <p>Current pressure sore measurements of the coccyx were documented on 11/2/11, as visualized stage 4 area of 0.8 cm length x 0.8 cm width and a depth of 0.6 cm.</p> <p>Her current care plan with an initiation date of 6/22/11, addressed the problem of alteration in skin integrity related to a pressure sore. Interventions included but were not limited to: pressure reducing mattress to bed, pressure reducing cushion to chair, and turn and reposition q (every) 2 hours and prn (whenever necessary).</p> <p>On 11/3/11 at 10:00 A.M., the RN unit manager for Resident #109, was made aware the Resident #109 was being observed for nursing care. She indicated at this time she would make nursing staff caring for Resident #109 aware of nursing care being observed. At this time 11/3/11 at 10:00 A.M., Resident #109 was observed up in her w/c (main dining room) with an anti pressure cushion in place.</p>		and quarterly thereafter.		

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	<p>On 11/3/11 at 11:12 A.M., Resident #109 remained up in her w/c in the hall by her room doorway. Resident #109 at this time was asked by Qualified Medication Aide(QMA) #1 if she needed to use the bathroom. The resident indicated she did not.</p> <p>On 11/3/11 at 11:40 A.M., during interview with QMA #1, she indicated before 10:00 A.M., today, Resident #109, had a large bm and soilage of her pressure sore dressing. The QMA indicated she had replaced the optimfoam dressing (outer dressing) and told the nurse who would do the complete pressure sore daily treatment including the packing of the wound.</p> <p>On 11/3/11 at 12:15 P.M., Resident #109 remained up in her w/c and was in the main dining room feeding herself lunch.</p> <p>On 11/3/11 at 12:45 P.M., Resident #109 was observed in her w/c, propelling herself back to her room from the main dining room.</p> <p>On 11/3/11 at 1:20 P.M., QMA #1 and CNA#1 assisted Resident #109 to transfer from her w/c to the commode for toileting. After toileting, CNA#1 and QMA #1, assisted Resident #109 to bed</p>			

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	<p>and Unit Manager RN #1 began coccyx pressure sore treatment. Unit Manager RN#1, then removed the old dressing, cleansed the pressure sore, packed the wound and applied the opti foam dressing as ordered. The open coccyx pressure area had clean defined edges without redness. This open area was approximately the size of a pencil eraser.</p> <p>On 11/9/11 at 9:55 A.M., the Director of Nursing (DON) and the MDS nurse were made aware of Resident #109 without position change from 10:00 A.M., on 11/3/11 to 1:20 P.M. The DON and MDS nurse were also made aware at this time that the complete treatment for the coccyx pressure sore was not completed by the nurse after the QMA initiated dressing change without packing of the ulcer before 10:00 A.M., on 11/3/11.</p> <p>3.1-40(a)(2)</p>				

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F0356 SS=A	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure daily nursing staffing posting was consistently displayed in a clear and readable manner for 4 of the first 5 days of survey. 10/30/11, 11/1/11, 11/2/11, 11/3/11.</p>	F0356	There were no residents affected by this deficient practice and none that were potentially affected.DHS inserviced on requirement to have daily staffing posted in a prominent place and in clear readable format at wheelchair height.Executive Director/ Designee will review daily staffing sheet to ensure that	12/09/2011	

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	<p>Findings include:</p> <p>On initial tour of the building on 10/30/11 at 4:50 P.M., the staffing sheet was observed on the wall across from the 100, 200 and 300 hall nursing station. The staffing sheet was posted at eye level for a 5 foot 3 inch person. The lettering on the posted staffing was written and was unable to be read from wheelchair height. The posted staffing was not at wheelchair height. The staffing was dated as 10/29/11.</p> <p>On 11/1/11 at 7:15 A.M., 11/2/11 8 A.M. and 11/3/11 at 8 A.M., the staffing for the 100, 200, 300 units was posted across from the nursing station on the wall, again at eye level for a 5 ft 3 inch person and not at wheelchair height.</p> <p>On 11/7/11 at 1 P.M., the Administrator was made aware of the posting of the nursing staffing not being at wheelchair height. She indicated the nursing posting should be at wheelchair height and readable.</p> <p>3.1-13(i)(4)</p>		it is posted in a readable prominent place at wheelchair height. Audit and compliance will be reported to QA committee monthly X 12 months.		
F0362 SS=F	The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. Based on observation and interview	F0362	There were no residents that	12/09/2011	

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	<p>the facility failed to provide routine dietary schedule staffing adequate for the 2nd shift as observed during 1 of 1 supper observations with the potential to affect 87 residents.</p> <p>Findings include:</p> <p>On 10/30/11 from 5:15 P.M. until 6:30 P.M., the ongoing supper meal preparation, service and sanitation was observed. Cook #1 was preparing multiple dishes and short orders in rapid succession. He used a long stainless steel food preparation table which became piled high in layers without open counter space or appropriate table surface sanitation. Co-mingled on and about the counter surface were stock supplies of foodstuffs and ingredients including ground chicken, cooked egg yolk, lettuce, tomato and spilled oil.</p> <p>The cook worked rapidly at preparing short orders without opportunity to store materials or cleanse the surface while continuing to prepare short orders and some plates from the steam table.</p> <p>At 5:50 P.M., there was a staff person at each of 3 doors, all at once, requesting "short" orders for different areas of the building. They stood and</p>		<p>were affected by this deficient practice. All residents have the potential to be affected and therefore, through alterations in staffing and inservicing will ensure that sufficient amount of staffing available to carry out the functions of dietary services. DFS inserviced on posting of staffing. Staffing schedule to be posted two weeks in advance. DFS to add an additional eight hour employee to the current staffing schedule daily. All dietary staff inserviced on proper food preparation to avoid food contamination. All dietary staff inserviced on proper technique for making sanitation water and for the proper way to utilize the sanitation water during food preparation. DFS to inservice staff on maintaining clean and organized work stations during food preparation. DFS to monitor all kitchen utensils and dispose/replace any utensils found to not meet regulations. DFS to monitor/update sanitation schedule. DFS/Designee to monitor daily dietary staffing 5 days/week X 4 weeks, 2x/week X 2 months, one time/week monthly thereafter. DFS will submit results of audits to QA committee monthly X 6 months then quarterly thereafter.</p>	

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	<p>waited to take the items back to their areas.</p> <p>Cook #1 indicated, during his work, that the chaotic situation was "pretty usual, maybe a little worse when we have stuffed peppers which many residents don't like." He indicated that all scheduled dietary staff were at work as usual during the meal.</p> <p>The dietary schedule, as reviewed at that time was consistent with the staff present.</p> <p>He stopped briefly to dish up a purred meal from the steam table. Both the pureed entree and the pureed vegetable product had been on the steam table without any covering. There was a thick paste crust on the surface approximately 1 inch deep that he included in each portion served.</p> <p>At the steam table, he noticed a plate, covered with a stainless steel lid with a round vent open at the top, sitting on the steam table counter. He had prepared it 22 minutes earlier for Resident #201. He indicated the resident had decided to eat in her room and he had forgotten the plate and so sent it out directly for service</p>				

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	<p>without checking temperature. He resumed serving.</p> <p>Throughout the food preparation observation, the following sanitation problems were noted:</p> <p>The handles and surrounding surfaces on drawers, refrigerators, freezers and all wooden doors were heavily soiled and tacky with hand soil and food matter. The walls and doors opening into 2 of 2 dining rooms were spattered with dry food matter built up.</p> <p>The putty colored molded plastic ice machine door was hand soiled to a medium gray with charcoal gray spots.</p> <p>The beverage refrigerator had uneven caulking around the interior chest bottom which had dark black mildew appearing matter lodged on and around the caulk.</p> <p>Three of 3 flatware utensil caddies and 4 of 4 drawers had accumulated dry foods in the bottom.</p> <p>The hand wash sink trap had accumulation of soil and water</p>				

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	<p>residue around faucet housing and scum buildup in the sink bowl. There was chicken and corn lodged in the drain guard of the handwash sink in amounts to indicate it had not been washed off hands. The back splash of the sink had scattered dry food debris.</p> <p>There was a white basting brush with once white bristles stored as clean, hanging on a storage board above the food prep counter .The bristles were laden with an accumulated yellow grease mass in which the bristles were imbedded.</p> <p>During interview on 11/7/11 at 10:25 AM the Food Service Manager (FSM), still orienting to the department, says he is revising the cleaning schedule related to cleaning problems he was informed of. He stated "They've been scheduled pretty short of staff and we are going to take care of that."</p> <p>During 3 of 4 confidential interviews with employees (3 10, 11, 12), working during the observed supper meal, the following comments were noted: "you just know when there's a request you're gonna have to wait but it isn't their fault, they are at top speed.", "you have to feel bad for</p>				

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F0364 SS=D	<p>them (staff)", "I am glad we have (name) in kitchen, he's young and can take the stress."</p> <p>3.1-20(h)</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure foods served to residents were maintained at a palatable temperature for 1 of 1 meals tested for temperature in the restorative dining room which had the potential to effect all 87 residents (excluding one resident who is tube fed). Resident B</p> <p>Findings include:</p> <p>On 10/6/11 at 6:10 P.M. Resident B was observed in the restorative dining room in her broda chair. The broda chair was in a reclined position by the dining room table. The resident was not eating or being fed. A plate of food was observed on the table in front of the resident but out of her reach. The plate was uncovered and there was no warming device observed for the plate. The resident's plate was observed to have two scoops of pureed food on it.</p>	F0364	Resident B suffered no ill effects form the alleged deficient practice and through corrective action and inservicing will ensure that residents food is served at the proper temperature. All residents have the potential to be affectd and therefore through alterations in food service and inservicing the staff will ensure that food served is at the proper temperature.DFS to discard all thermometers not functioning properly. All dietary staff inserviced on utilization of food thermometers, proper calibration, and proper food temperatures. Systemic change to hold pureed foods on steam table until food is to be served to resident to maintain proper temperature.DFS/DHS/Designee to monitor food temperature of 3 residents food/ day X 2 weeks, 3 residents food temps weekly X 4 weeks, then 3 resident food temperatures monthly thereafter. Results of audits to be reviewed in QA committee monthly X 6	12/09/2011

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	<p>At 6:15 P.M., LPN #1 was interviewed. She indicated the pureed food on the plate, included but was not limited to, pureed stuffed green peppers. LPN #1 then prepared to feed the resident. At this time, a thermometer was obtained from Cook #1 in the kitchen. When the thermometer was obtained from Cook #1, the round dial face of the thermometer was observed to have clear sticky residue on the face of the thermometer dial. Cook #1 indicated this thermometer had been calibrated for use. Prior to using the thermometer, this residue was scraped off so the dial was visible. Prior to inserting the thermometer into the scoop of pureed stuffed green pepper, LPN #1 read the temperature on the thermometer dial as 46 degrees. The facility thermometer was placed into the scoop of pureed green pepper, not touching the bottom of the plate. After the thermometer needles on the dial stopped moving, the temperature was read by LPN #1 at 76 degrees. LPN #1 then touched the bottom of the plate and indicated it felt "lukewarm." At 6:20 P.M. another thermometer was obtained from Cook #1 in the kitchen. In the restorative dining room, CNA #1 read this thermometer temperature, prior to inserting it into the scoop of pureed stuffed green pepper, as 62 degrees. After the thermometer was held in the scoop of</p>		<p>months and quarterly thereafter.</p>	

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	<p>pureed stuffed green pepper until the thermometer needle stopped moving and CNA #1 read the temperature as 85 degrees.</p> <p>On 10/31/11 at 1 P.M. the clinical record of Resident B was reviewed. The most recent MDS (minimum data set assessment) dated 9/14/11, indicated the resident had severe cognitive impairment and extensive assistance was required for eating.</p> <p>On 11/1/11 at 11:30 A.M. a confidential family interview was conducted with family member #2. This family member indicated that "sometimes the food is cold..."</p> <p>On 11/3/11 at 1:35 P.M. a current copy of the facility policy and procedure for "Food Temperatures - Serving Line" was received from the FSM. The FSM indicated this policy was current and had a recent date of 2009. The procedure included, but was not limited to, the following: "Hot foods in the steam table are maintained at or over 135 degrees F (Fahrenheit) so that items arrive at approximately 120 degrees Fahrenheit or over when the resident is served. Exceptions include foods such as hot bread, bacon and eggs...Temperatures are taken prior to service to ensure hot foods</p>			

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	<p>and cold foods are maintained at the above temperatures...Proper procedures are used so that measured temperatures are accurate and contamination is prevented:</p> <p>On 11/3/11 at 2 P.M., FSM #2 (from another a sister facility) and AFSM (assistant food service manager) were interviewed. He indicated the thermometers are read Fahrenheit. He also indicated that the food thermometer should read "zero" before it is placed in the food to check the temperature.</p> <p>This Federal tag relates to complaint #IN00098222.</p> <p>3.1-21(a)(2)</p>				

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F0365 SS=D	<p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, interview and record review, the facility failed to ensure food preferences were honored for 1 of 1 resident's reviewed requesting extra gravy in a Stage 2 sample of 21.</p> <p>Resident A, Family Member #1</p> <p>Findings include:</p> <p>On 10/30/11 at 5:30 P.M., Resident A was observed in the dining room. He had a plate in front of him which had a large amount of ground meat of at least 2 cups in quantity. There was a thin ribbon of gravy on top of the meat, which appeared to be no more than 2 fluid ounces.</p> <p>A current physician diet order for October 2011 indicated the resident was to be on a "Regular, ground meat per resident/family request."</p> <p>On 11/1/11 at 11:17 A.M. a confidential interview was conducted with a family member #1. This family member indicated the "meals served not always according to what the resident orders..."</p> <p>On 11/1/11 at 2 P.M., the Administrator (ADM) provided a copy the Resident A's dietary card. This card is observed to be</p>	F0365	<p>Resident A suffered no ill effects from the alleged deficient practice and through corrective action and inservicing will ensure that residents food is served in a form to meet resident's individual needs. All resident's have the potential to be affected and therefore through inservicing will assure that resident's individual food choices are maintained. Systemic change is to have all resident food preferences to be updated. All staff will be inserviced on interpretive guidelines as it pertains to residents rights for food selection. DFS//Designee to monitor 3 residents meal tickets during meals to assure they are receiving food selection requested X 2 weeks, 3 residents weekly X 4 weeks, then 3 residents meal tickets monthly thereafter. Audit forms to be submitted to QA committee monthly X 6 months then quarterly thereafter.</p>	12/09/2011	

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	<p>used by the dietary staff serving meals in the main dining room and is delivered to the table with the residents plate. This dietary card indicated the following for the resident: "Extra gravy on meats."</p> <p>On 11/3/11 2 P.M., the AFSM (assistant food service manager) and FSM (food service manager #2) were interviewed. At this time they provided a copy of the recipe for "chicken Grnd (ground)." The AFSM indicated a serving of ground meat was a 4 ounce or 1/2 cup scoop and this amount of meat was to have 2 fluid ounces of gravy over it. At this time, the FSM #2 indicated the extra gravy on the resident's tray card was due to the resident's request. FSM #2 indicated gravy is put on ground meat as a binder since ground meat has the potential to choke a resident. The AFSM indicated that sometimes Resident A will request to not have any gravy on his ground meat.</p> <p>This Federal tag cited relates to complaint #IN00098222</p> <p>3.1-21(a)(3)</p>				

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to prepare and serve meals and store foods under sanitary conditions during 1 of 1 evening meal observation with the potential to impact 87 certified residents.</p> <p>Findings include:</p> <p>On 10/30/11 from 5:15 P.M. until 6:30 P.M. ongoing supper meal preparation, service and sanitation was observed. Cook #1 was preparing multiple dishes and short orders in rapid succession. He used a long stainless steel food preparation table which became piled high in layers without counter space or appropriate table surface sanitation.</p> <p>On the counter there was a food processor with ground cooked chicken in the bottom. There was</p>	F0371	<p>There were no residents affected by this deficient practice. All residents have the potential to be affected and therefore through alterations in food preparation and inservicing will ensure that sanitation is maintained. All dietary staff to be inserviced on proper cleaning of work station prior to food preparation, proper food handling to avoid cross contamination, proper technique and concentration of sanitizing water. DFS to implement and monitor dietary cleaning schedules. DFS/Designee to monitor dietary cleaning schedule, food preparation, pre-food prep sanitation including; mixture of sanitary solution and preparation of work stations, for 2 meals daily X 2 weeks, 1 meal daily X 4 weeks, then 1 meal daily thereafter. DFS/Designee is to submit audit forms to ED weekly. ED to review audit forms with the QA committee monthly X 6 months then quarterly thereafter.</p>	12/09/2011

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	<p>approximately 3/4 to 1 cup of ground chicken scattered across the food prep surface. On top of the chicken, there was 1 loaf of sliced bread in an open plastic bag with slices spilling atop the chicken onto the surface. There was an open bun package. There was an open jar of beef base with the lid placed, top down, on some shredded lettuce and chicken. There was a package of cheese slices on top of the bread bag. There was a cutting board (placed on top of the chicken) with a white plastic handled knife. The handle had been melted and burned into a deformed, twisted shape and has visible food dried and trapped within the contortions of the handle. On the board there was shredded parsley, a half tomato wedge with one half of a white label stuck to the skin. There were 2 diced pieces of the tomato with remnants of the white label still on the skin. There were scattered cooked egg yolk pieces on the board and spilled onto the surface. Also there was a plastic container of yellow grease and a greasy basting brush with bristles on the bare surface. There was a paper butter wrapper, placed butter side up, on the counter. There were salt and pepper containers and a slightly moist balled up rag with shredded stringy edges</p>			

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	<p>and food matter in it. There was a pitcher of milk sitting on loose smashed corn kernels. There was a spray can of non stick cooking spray. There were 4 bowls of bread slurry on the surface, one with the edge of the plastic bun bag in the slurry.</p> <p>There was an open can of tomato soup concentrate with dried soup on the inside of the still attached can lid. Cook #1 indicated he did not know who opened it or when it was opened or how the can got on the surface he is working on.</p> <p>The cook worked rapidly at preparing short orders without opportunity to store materials or cleanse the surface while continuing to prepare some plates from the steam table.</p> <p>There was a staff person at each of 3 doors, all at once, requesting "short" orders for different areas of the building. They stood and waited to take the items back to their areas.</p> <p>Cook #1 indicated, during his work, that the chaotic situation was "pretty usual, maybe a little worse when we have stuffed peppers which many residents don't like." He indicated that all scheduled dietary staff were at</p>			

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	<p>work as usual during the meal.</p> <p>Cook #1 began making a peanut butter and jelly sandwich (PBJ). He used the bread that had spilled out of the bag, onto the ground chicken on the prep counter. He put both the PB and J jars down in the chicken with the PB Jar also on top of the butter wrapper. He removed jar lids and placed them, lid tops down, in the chicken. He made the sandwich on the counter, laying the PB spreading knife on the counter and sends the sandwich out for service. A cheese sandwich was then assembled in like fashion under the same circumstances.</p> <p>He stopped briefly to dish up a purred meal from the steam table. Both the pureed entree and the pureed vegetable product had been on the steam table without any covering. There was a thick paste crust on the surface approximately 1 inch deep that he included in each portion served.</p> <p>At the steam table he noticed a plate, covered with a stainless steel lid with a round vent open at the top, sitting on the steam table counter. He had prepared it 22 minutes earlier for Resident #201. He indicated the</p>				

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	<p>resident had decided to eat in her room and he had forgotten the plate and so sent it out directly for service without checking temperature. He resumed serving.</p> <p>Food Service Assistant (FSA) #1 on the cutting board, she added hard boiled egg to a chef salad and then began clearing the food preparation counter. She was wearing a wrist watch. The band, which fit snugly at wrist level, had a dried cream colored matter on it.</p> <p>She put away items off the food prep counter. She puts the lids, which had been placed on in the chicken, back onto the PB and J jars and returned the jars back to storage. The PB jar was returned with chicken shreds on the bottom of the jar stuck to the butter from the wrapper it had been placed on.</p> <p>At 6:12 P.M., Cook #1 indicated he was familiar with checking sanitizing solution for the food prep surface. There was one red bucket under the food prep counter. It contained approximately 3 inches of medium gray opaque solution and a rag floating in it with food that was not served at this meal. He tested it and indicated it should be 200 ppm,</p>			

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	<p>however the solution tested that there was no sanitizing chemical in it. He stated "well, but it hasn't been used since well before dinner, not sure of the time."</p> <p>Throughout the food preparation observation the following sanitation problems were noted:</p> <p>The handles and surrounding surfaces on drawers, refrigerators, freezers and all wooden doors were heavily soiled and tacky with hand soil and food matter.</p> <p>The walls and doors opening into 2 of 2 dining rooms were spattered with dry food matter built up.</p> <p>Three of 4 knives and 4 of 5 stored utensils had melted and burned, unsmooth handles.</p> <p>There were 12 of 12 pureed food forms melted with brown curled brittle jagged edges.</p> <p>The putty colored molded plastic ice machine door was hand soiled to a medium gray with charcoal gray spots. The door did not seal shut but left a 2 inch gap over the chest. The door had a corner chip missing which</p>			

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	<p>exposed insulation material.</p> <p>The beverage refrigerator wire shelving surfaces had the finish deteriorated chipped and worn into un smooth surfaces. The floor of the refrigerator had uneven caulking around the interior chest bottom which had dark black mildew appearing matter lodged on and around the caulk.</p> <p>There was 1 of 1 butcher knife which had a soft rubber handle which was deteriorated with grips worn off and unsmooth.</p> <p>Three of 3 flatware utensil caddies and 4 of 4 drawers had accumulated dry foods in the bottom.</p> <p>The hand wash sink trap had accumulation of soil and water residue around faucet housing and scum buildup in the sink bowl. There was chicken and corn lodged in the drain guard of the handwash sink in amounts to indicate it had not been washed off hands. The back splash of the sink had scattered dry food debris.</p> <p>There was a white basting brush with once white bristles stored as clean, hanging on a storage board above the</p>			

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	<p>food prep counter .The bristles were laden with an accumulated yellow grease mass in which the bristles were imbedded.</p> <p>During interview on 11/7/11 at 10:25 AM the Food Service Manager (FSM), still orienting to the department, says he is revising the cleaning schedule related to cleaning problems he was informed of. He stated "They've been scheduled pretty short of staff and we are going to take care of that."</p> <p>The Registered Dietician was interviewed 11/7/11 at 11:00 A.M. regarding the problems noted in the kitchen and her job responsibilities. She indicated that's why I am working out the remainder of my resignation notice to this corporation because they are not structured for any hours (during which the RD could have input on sanitation or food preparation) beyond just clinical reviews.</p> <p>The administrator was interviewed 11/7/11 at 1:00 P.M., regarding quality assessment of food preparation and sanitation practices. She provided monitoring tools which excluded actual observation of practice. She indicated documentation was lacking to verify staff food handling and processing were periodically</p>				

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R0304	<p>monitored for implementation of sanitation principles.</p> <p>An undated, un referenced Policy and Procedure titled "Sanitation Water, Sink, Buckets to insure sanitation water is correct" was provided by the FSM 11/4/11 at 8:20 A.M. It directed "Red buckets are used for food contact areas...buckets should be checked every 2 hours and refilled if PPM(parts per million) falls under 200 ppm...all buckets are changed after each meal.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>(e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication refrigerator was locked for 2 of 2 days of residential unit observation which had the potential to affect all 20 residential residents. 11/4/11 and 11/7/11</p>	R0304	There were no residents affected by the deficient practice and through inservicing will ensure that the refrigerator remains locked.Assited living nursing staff will be inserviced on proper drug storage policy and procedure.DHS/Designee will perform 3 random refrigerator checks weekly for 3 months and	12/11/2011	

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	<p>Findings include:</p> <p>On 11/4/11 at 7:55 A.M., the Residential Nursing unit station was observed. The nursing station was located at the juncture of two long halls, with two sides of the square shaped nursing station open to the hallways. The two sides of the nursing station were exposed to the halls which were separated by a counter. The entrance into the nursing station was open, with no door or device to prevent entrance into the station area. In the back corner of the nursing station, sitting on a counter was a small, dorm sized refrigerator. This refrigerator was visible from both hallways bordering the nursing station. A locking mechanism was observed on the refrigerator in which a pad lock could be inserted and closed to prevent the refrigerator door from being opened. One part of this locking mechanism was attached to the refrigerator door and the other part was attached to the side of the refrigerator. When these two devices were overlapped, a pad lock could be inserted, closed and prevent the refrigerator door from being opened. No staff was observed in the nursing station area at this time.</p> <p>At this time, the pad lock was observed hanging open on the portion of the locking mechanism attached to the</p>		<p>then 3 random refrigerator checks monthly thereafter. Results of audits will be forwarded to QA committee monthly X 6 months and then quarterly for review and further suggestion.</p>	

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	<p>refrigerator door. Due to the placement of the pad lock and the observation on the two locking devices not being overlapped, the refrigerator was able to be opened.</p> <p>At 8:10 A.M., no staff were observed in the nursing station area and the medication refrigerator was unlocked.</p> <p>At 9:30 A.M., LPN #3 was interviewed. Without using a key, LPN #3 opened the medication refrigerator located on the counter in the nursing station. She indicated the following medications were in the unlocked refrigerator: 1 vial of flu vaccine; two vials of Novolin R insulin; Bisacodyl and tylenol suppositories. After LPN#3 removed the above medications from the refrigerator, she returned the medications to the refrigerator and didn't lock the refrigerator.</p> <p>At 11 A.M., the medication refrigerator continued unlocked as above.</p> <p>On 11/7/11 at 7:30 A.M., the medication refrigerator had the two pieces of the locking device were overlapped and the pad lock in place but the pad lock was not engaged, so the medication refrigerator remains unlocked. No staff was in the nursing station at this time.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN47586		
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	<p>At 10 A.M., the medication refrigerator remained unlocked. Again, no nursing staff were present in the nursing station.</p> <p>On 11/7/11 at 1 P.M., the DON (Director of Nursing) was made aware of the medication refrigerator being unlocked. She indicated the medication refrigerator should be locked.</p> <p>On 11/7/11 at 2 P.M., the DON provided a current copy of the facility policy and procedure for "Medication Storage in the facility." This policy was dated 2/1/10. The policy included but was not limited to, the following: "...Medication rooms, carts and medication supplies are locked or attended by persons with authorized access..."</p>				