

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/19/2015
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NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 11, 12, 13, 14, 17, 18 and 19, 2015</p> <p>Facility number: 000447 Provider number: 155551 AIM number: 100289950</p> <p>Census bed type: SNF/NF: 85 Total: 85</p> <p>Census payor type: Medicare: 7 Medicaid: 39 Other: 39 Total: 85</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>We at the facility are hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with</p>			

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>the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure behavioral symptoms were addressed without psychotropic medications being used or increased without indication other than dementia for 1 of 5 residents reviewed for unnecessary medication use. (Resident # 46)</p> <p>Findings include:</p> <p>Review of Resident #46's clinical record began on 8/11/2015 at 2:38 p.m. Diagnoses included, but were not limited to, generalized anxiety disorder, depression, Alzheimer's disease, dementia without behavioral disturbance, and unspecified psychosis.</p> <p>Resident #46's current physician's orders indicated the resident was prescribed the following psychotropic medications: alprazolam 0.25 mg twice daily (an anti-anxiety) and risperidone 0.25 mg twice daily (an anti-psychotic).</p> <p>Resident #46 had a current, 60-day Minimum Data Set (MDS) assessment, dated 7/17/15, which indicated the resident had severe cognitive impairment.</p> <p>A document titled, "Discharge</p>	F 0309	<p>Resident#46 has had no adverse reactions as a result of this deficient practice. Resident #46's medication was reviewed by the facility Psychiatrist and reduced accordingly. All other residents residing in the facility that receive psychoactive medication have the potential to be affected by this deficient practice. All residents on psychoactive medication have been reviewed to ensure there is a schedule for gradual dose reduction in place unless clinically contraindicated by the Psychiatrist or physician. The facility Psychiatrist will continue with monthly review and management of residents receiving psychoactive medications. The facility policy and procedure for Psychoactive medications and Gradual Dose Reduction was reviewed and no changes were indicated. Facility staff were re-inserviced by the Social Service Director regarding the facility policy and procedure for Behavior Management and Psychoactive medications and Gradual Dose Reduction. TheSSD and/or designee will complete the Behavior and Psychoactive medication review form (Attachment A) weekly for four weeks, every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. Monitoring will continue until</p>	09/18/2015

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	<p>Summary", dated 4/29/15, and labeled "5/20/15 ...Admission Orders/Discharge Summary...." indicated the resident was receiving the following psychotropic medications upon admission to the facility: alprazolam 0.25 mg three times a day as needed for anxiety and risperidone 0.25 mg once daily.</p> <p>A "Nurses Note", dated 5/21/15 at 10:10 a.m., indicated a new order was received to increase Resident #46's alprazolam to 0.25 mg twice daily routinely.</p> <p>There was no indication documented in the resident's clinical record for the increase in dosage.</p> <p>During an interview with the Social Service Director (SSD) on 8/19/15 at 8:17 a.m., she indicated the medication was increased in anticipation of anxiety symptoms due to the resident having resided in the facility at a prior date.</p> <p>Review of a document titled, "Behavior Sheet", dated 5/28/15, indicated Resident #46 believed she was at the facility to work and repeatedly asked where her room was.</p> <p>Review of a document titled, "Behavior Sheet", dated 6/7/15, indicated Resident #46 was tearful due to believing her son</p>		substantial compliance is achieved as determined by the Quality Assurance committee. The SSD report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly				

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	<p>was supposed to take her home and she did not recall having been at the facility before.</p> <p>There were no other episodes of behavior documented in the resident's clinical record for May and June 2015.</p> <p>A "Consultation Report" from the Consultant Pharmacist, dated 5/28/15, recommended reducing the resident's risperidone dosage due to Resident #46's diagnosis of dementia. The recommendation was declined by the facility nurse practitioner on 6/4/15 due to plans for the resident to return home.</p> <p>A "Social Service Note", dated 6/22/15, indicated the resident would not be returning home and was to reside in the facility on a long-term basis.</p> <p>The clinical record indicated the resident was seen by the facility psychiatrist for an initial exam on 6/23/15 for dementia, depression, and delusions.</p> <p>A "Nurses Note", dated 6/27/15 at 4:53 p.m., indicated a new order was received from the psychiatrist to increase Resident #46's risperidone to 0.25 mg twice daily.</p> <p>No other behaviors were documented in the clinical record. No</p>			

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F 0333 SS=D Bldg. 00	<p>non-pharmacological interventions were documented to prevent behaviors by the resident. No other information was provided.</p> <p>3.1-37(a)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to prevent a medication error related to a physician order to decrease an antidepressant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #20)</p> <p>Findings include:</p> <p>The clinical record for Resident #20 was reviewed on 8/17/15 at 11:36 a.m. Diagnoses included, but were not limited to, diabetes mellitus type II, Alzheimer's disease, insomnia, anxiety, restlessness and agitation, major depressive disorder, and unspecified psychosis not due to a substance or known physiological condition.</p> <p>The resident was currently receiving the following medication: Remeron (an antidepressant medication) 15 milligrams</p>	F 0333	<p>Facility Plan of Correction: Resident #20 had no adverse reactions related to this alleged deficient practice. All residents residing in the facility that receive medication have the potential to be affected by this alleged deficient practice. Nursing staff were re-inserviced regarding the facility policy and procedure for Physicians' Orders. The DON/designee will randomly audit five physician orders a week for completion and implementation, the audit will be documented on the Physician order log (Attachment B). The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The DON report of monitoring will be forwarded to the Administrator for</p>	08/19/2015

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	<p>by mouth at bedtime for appetite stimulant with an order date of 10/14/13.</p> <p>A review of a "Physician Progress Note," with an electronic Physician signature, date of 1/9/2014, was provided by the Director of Nursing (DON) on 8/17/15 at 4:53 p.m. and indicated the following:</p> <p>"...5. weight gain-pt [patient] was started on Remeron for appetite supplement, given weight gain, elevated sugars and lipids. decrease [Decrease] to 7.5 mg [milligrams] andcont [and continue] monitoring weight...."</p> <p>A review of the "MEDICATION ADMINISTRATION RECORD" for July 2014, April 2015, May 2015, June 2015, July 2015, and August 2015 indicated the following:</p> <p>"Remeron Tablet 15 MG [milligrams] (Mirtazapine) Give 15 mg [milligrams] by mouth at bedtime for Appetite stimulant -Start Date- 10/14/2013... -D/C [Discontinue] - 8/18/2015 1421 [2:21 p.m.]</p> <p>The "MEDICATION ADMINISTRATION RECORD" for the</p>		<p>monthly QA review and the plan of action will be adjusted accordingly. Facility Provided Information for IDR: The facility respectfully requests the review of the following information and accompanying attachments (Attachment C). Clinical Chart review was completed for resident#20. Remeron was ordered for resident #20 on 10/14/13 for the indication of an appetite stimulant. The resident was evaluated during a normal monthly visit by the Nurse Practitioner (NP) on 12/31/13. The NP transcribed in her note to decrease the remeron to 7.5mg daily. On01/01/14 at 10:00, a call was placed to clarify the order related to the resident having skin breakdown over her coccyx area. The NP revised the order to continue with the previous order of remeron 15mg daily related to concern regarding the residents varying intakes and need to maintain adequate protein and caloric intake. The clarification was made before the scheduled dose was to be given at 8:00pm. On 01/09/15 the MD reviewed the NP's transcribed note for accuracy and signed off on its content. No further changes were indicated by the MD. On 08/18/15, the Medical Director was updated regarding the concern related to the medication and a new order was received to discontinue the medication at this</p>				

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	<p>previous dates indicated the medication Remeron was administered and not decreased or discontinued until 8/18/15, after it was brought to the attention of the DON.</p> <p>A review of the current "ROLLING MEADOWS HEALTH AND REHABILITATION CENTER ORDER SUMMARY REPORT" provided by the Social Service Director on 8/17/15 at 4:15 p.m., indicated the following:</p> <p>"...Remeron Tablet 15 MG (milligrams) (Mirtazapine) Give 15 mg by mouth at bedtime for Appetite stimulant...order date 10/14/13...."</p> <p>A review of the "ROLLING MEADOWS HEALTH AND REHABILITATION CENTER MEDICATION REVIEW REPORT" for the month of July 2014 indicated the following:</p> <p>"...Remeron Tablet 15 MG (Mirtazapine) Give 15 mg by mouth at bedtime for Appetite stimulant...order date 10/14/2013.</p> <p>During an interview with the DON on 8/18/15 at 1:50 p.m., she indicated there was a medication error for Resident #20 for the medication Remeron. She indicated Remeron should have been</p>		<p>time. During discussion with the primary care physician/Medical Director (MD) the MD stated that he does not modify the plan for treatment when he is reviewing the NP's progress noted. The MD stated he reviews the progress notes for timely completion and thoroughness. In addition, he stated that if he elected to modify an order that was transcribed on a progress note that he would contact a nurse at the facility and provide verbal directions to modify an order. A medication error did not occur because the order was clarified with the Nurse Practitioner and the Nurse Practitioner indicated she did not realize the resident currently had skin breakdown so therefore she wanted the order to remain 15mg daily. The resident was evaluated by either the Nurse Practitioner or MD every other month from December 2013 to present. The NP and MD chose not to decrease or discontinue the medication as indicated for an appetite stimulant related to the residents varying meal intakes and her diagnosis of Diabetes Mellitus, fluctuating blood sugars, and skin breakdown. The resident was reviewed by the Registered Dietician (RD) on 05/31/13, 04/10/14, 01/30/15, and 05/15/15. The RD completed the Annual Risk for Malnutrition Assessment on 05/13/13, 04/10/14, and 01/30/15 and noted the resident to be at risk for</p>	

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F 0431 SS=A Bldg. 00	<p>decreased on 1/9/14 and was not.</p> <p>During an interview with the DON and the Nurse Consultant on 8/18/15 at 4:00 p.m., the DON indicated the medication Remeron for Resident #20 was discontinued on 8/18/15.</p> <p>A review of the policy titled "ADMINISTRATIVE PHYSICIAN'S ORDERS", with a revised date of 1/2012, provided by the Administrator on 8/19/15 at 9:36 a.m., indicated the following:</p> <p>"...Purpose: To provide general guidelines when receiving, transcribing, notification, and care planning physician's orders...</p> <p>...5. Following a physician visit, a licensed nurse will: ...Check for any orders that require verification...."</p> <p>3.1-25(b)(9)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug</p>		<p>malnutrition. The resident has been followed by the nationally accredited Wound Care Certified nurse (WCC) from 04/29/2011 to current. The WCC was consulted and she re-iterated the importance of the resident receiving an appetite stimulant related to her multiple frequent areas of skin breakdown and requirement for adequate protein and caloric intake. Residents' meal intakes reviewed from December 2013 thru August 2015. Intakes noted to have frequent variance ranging from 0%-100%.</p>	

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	<p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to maintain the proper storage of medication for an undetermined amount of time for 1 of 3 refrigerators observed for medication storage.</p> <p>Findings include:</p> <p>On 08/18/2015 at 9:06 a.m., during observation of the medication storage</p>	F 0431	<p>Facility Plan of Correction: No residents were negatively affected by this practice. All residents who reside in the facility that receive individualized drugs and/or biologicals that are stored by authorized personnel of the facility have the potential to be affected by this practice. The facility policy and procedure for Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles reviewed with no changes indicated. The</p>	08/19/2015

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	<p>areas with the Director of Nursing (DON), the temperature in the Birch Hall refrigerator, containing Novolog and Levemir (insulin), was observed to be 52 degrees. The temperature log indicated there had been no temperature checked 8/18/2015. The DON indicated the thermometer must be broken. She then obtained a new thermometer and placed the new thermometer into the refrigerator. The DON requested that we come back to recheck the temperature after looking at the other medication storage areas.</p> <p>On 08/18/2015 at 9:38 a.m., the temperature of the refrigerator in the Birch Hall medication storage room was rechecked by the DON and was observed to be 52 degrees. Novolog and Levemir were still being contained in the refrigerator at this time. The DON again requested that we recheck the temperature at a later time.</p> <p>On 08/18/2015 at 10:04 a.m., the refrigerator in the Birch Hall medication storage room was rechecked by the DON and was 52 degrees. Novolog and Levemir were still being contained in the refrigerator at this time.</p> <p>On 08/18/2015 at 10:15 a.m., the DON indicated the medications from the Birch</p>		<p>facility nursing staff was re-inserviced on the facility policy and procedure for Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles. The DON and/or designee will randomly audit medication and treatment carts weekly for four weeks, then every other week for four weeks, then monthly thereafter. The audit will be documented on the Medication Storage review form (Attachment D). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The DON report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. Facility Provided Information for IDR: The facility respectfully requests the review of the following information and accompanying attachments (Attachment E). On 08/18/15 at 9:06am during the observation of the medication storage areas by the Director of Nursing (DON) and Surveyor, the Birch Lane refrigerator temperature was observed to be 52 degrees. Both the DON and the surveyor touched the items in the refrigerator and agreed they felt cool. The thermometer in the Birch lane refrigerator was immediately replaced at 9:15am by the Assistant Director of</p>	

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	<p>Hall medication room refrigerator had been moved to the Maple Hall medication room refrigerator.</p> <p>On 08/18/2015 at 10:12 a.m., a review of the policy titled "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles", dated 12/01/07, was provided by the DON. This policy indicated the "Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopoeia guidelines for temperature ranges...1.2 Refrigeration: 36-46 degrees Fahrenheit...."</p> <p>On 8/18/2015 at 10:21 a.m., a review of the "Fridge Temp Log", for August 2015 provided by the DON, indicated the last temperature taken was on 8/17/2015. A note at the bottom of the paper indicated to complete the log for the "...date your shift starts...."</p> <p>On 08/18/2015 at 10:30 a.m., the manufacturer's recommendations for Levemir indicated the medication should be stored at 36-46 degrees Fahrenheit.</p> <p>On 08/18/2015 at 11:00 a.m., during an interview with the DON, she indicated the refrigerator temperatures are checked everyday on 3rd shift and confirmed the</p>		<p>Nursing. Several licensed staff members were frequently observing the thermometer for accuracy. Licensed staff members were encouraged to decrease frequent observation of the refrigerator to allow the newly placed thermometer appropriate time to accurately calibrate to the refrigerators accurate temperature. No additional settings or variables were modified in relation to the refrigerator. All other medication storage areas including refrigerators were observed by the DON and Surveyor and no concerns were noted. The refrigerator was observed again at approximately 10:20am by the Director of Nursing and the Surveyor as the refrigerator temperature was observed to be 42 degrees. A call was placed to the Omnicare pharmacy by the Assistant Director of Nursing (ADON) and the Omnicare Pharmacist informed the ADON that none of the medications (Bisacodyl suppositories, Acetaminophen suppositories, levemir, and Novolog) would have been affected if the temperature was verifiably inaccurate. The pharmacist representing Omnicare stated that the temperature would have to be out of the intended parameters for an extensive period of time. In addition, the pharmacist stated that because the last documented temperature on 08/17/15 was</p>				

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	<p>last temperature documented was at the beginning of 3rd shift on 8/17/2015.</p> <p>On 08/19/2015 at 08:45 a.m., a review of the Lippincott Williams & Wilkins Nursing 2014 Drug Handbook, 34th Edition, copy right 2014, indicated Levemir should be stored in a refrigerator between 36F and 46F degrees Fahrenheit. Lippincott also indicated Novolog was to be stored between 36- 46 degrees Fahrenheit.</p> <p>3.1-25(m)</p>		<p>within the recommended parameters of 36-46 degrees F that the possible duration of temperature between observation times would not inadvertently affect any medications being stored in the refrigerator.</p> <p><i>Mosby's 2015 Nursing Drug Reference</i>, 28th edition, copy right 2015 indicated Levemir and Novolog should be stored at room temperature for < 1 month; keep away from heat and sunlight; refrigerate all other supply. The <i>Mosby's 2015 Nursing Drug Reference</i>, 28th edition, copy right 2015 has no recommendations for the storage of Bisacodyl Suppositories or Acetaminophen suppositories. The Manufacturer of Bisacodyl and Acetaminophen suppositories was contacted and they supplied handouts with the following information, "store at room temperature below 27 degrees C (80degrees F). Protect from moisture and heat. The manufacturer of Novolog and Levemir were contacted representatives from both manufacturers stated that the informational pamphlet they provide contains the instructions for usage: do not use if frozen, keep away from heat or light, store opened or unopened vials in the refrigerator at 36-46 degrees F, and opened vials may be stored out of the refrigerator below 86 degrees F. Representatives from both</p>		

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			Novolog and Levemir stated that the medication would not have been adversely affected during the time frame of 6pm on 08/17/15 to 08/18/15 at 9:06am. Representatives from both Novolog and Levemir recommended treating the insulin as if it was an opened vial and placing a date open sticker at then utilizing the insulin for up to 28days. A date open sticker was placed on the vials of novlog and levemir on 08/18/15 with instructions to dispose after 28 days. The manufacturer of the Pelouze Thermometer that was placed in the fridge on 08/18/15 at 9:15am was contacted; the manufacturer stated they recommend waiting up to 30 minutes for calibration and that it could also depend if the door is opened often, or how large the room is but as a general rule, wait 30 minutes. The daily refrigerator temperature log for August was reviewed, the instructions for the form are to complete for the date your shift starts. The licensed nurse on the 6p-6a shift is delegated to observe and document the temperature at the beginning of the nurses' shift at 6pm. At the time of the survey the form had been completed up until August 17th. The form had not yet been completed for August 18th because it was not due to be completed until 6pm that evening at the beginning of the licensed nurses' shift. The daily	

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F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin</p>		refrigerator temperature log was reviewed and all previous temperatures for the previous six months were noted to be between 36 and 46 degrees Fahrenheit. The Omnicare Pharmacies Monthly Survey of MedicationRoom/Cart Inspection Reports was reviewed for the previous six months and the refrigerator temperatures were noted to be between 36-46 degrees.	

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	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure infection control practices were followed during administration of eye drops for 1 of 2 residents observed receiving eye drops and during ice pass for 2 of 4 hallways (Birch and Maple) in the facility. (LPN#1; Resident #21) (CNA#2; CNA#1)</p> <p>Findings include:</p> <p>1. During a medication observation beginning on 8/18/15 at 11:31 a.m., LPN #1 was observed to remove Resident #21's prescribed eye drops and 2 exam gloves from the medication cart. LPN #1 then entered the shower room, where Resident #21 was waiting, and approached the sink. LPN #1 sat the bottle of eye drops on the sink to the left of the faucet and placed the gloves on the left edge of the sink. After washing her hands, LPN #1 then applied the gloves to</p>	F 0441	<p>No residents have had any adverse reactions related to this deficient practice. All residents residing in the facility have the potential to be affected by this deficient practice. An Ice scoop holder was purchased and attached to both ice chests utilized to pass ice on the hallways. Nursing staff were re-inserviced by the Director of Nursing regarding Facility Infection Control Practices. The DON and/or designee will complete the Infection Control Resident and Staff Surveillance form (Attachment F) weekly for four weeks, every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The DON report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.</p>	09/18/2015

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	<p>her hands, removed the eye drops from the sink, and administered the eye drops to Resident #21. She contaminated the procedure by placing the eye drops and gloves on the sink while washing her hands.</p> <p>On 8/18/15 at 2:11 p.m., CNA #2 was observed opening a cooler of ice in the hallway of the Birch Hall. Inside the cooler was a metal scoop, sitting inside the ice cubes. CNA #2 scooped ice from the cooler with her right hand, placed it in a pitcher she was holding in her left hand, closed the cooler lid, and entered room 309. She contaminated the ice with the scoop used.</p> <p>2. On 08/17/2015 at 2:14 p.m., the ice cooler was filled with ice and observed to be in the middle of the Maple Hall with the lid open and the metal ice scoop was observed in the ice. CNA #1 approached the ice cooler, closed the cooler lid and pulled it in front of resident room 111. CNA #1 then opened the cooler, took the metal ice scoop out and scooped ice for the resident residing in Room 111.</p> <p>On 08/18/2015 at 2:09 p.m., CNA #2 was observed passing ice on the Birch Hall, she placed the metal ice scoop inside the ice cooler and scooped the ice into a cup and then placed the metal ice scoop back into the ice cooler and closed the lid. She</p>			

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	<p>was then observed to serve the cup of ice to the resident in 309 A .</p> <p>On 08/18/2015 at 2:11 p.m., CNA #2 was observed to open the cooler of ice, pick up the metal ice scoop that was inside, scoop ice into a cup and then serve the ice to the resident residing in 309 B.</p> <p>On 08/18/2015 at 2:17 p.m., during an interview with CNA #2, she indicated that she served 20 residents ice in the afternoon on the Birch hall.</p> <p>On 08/19/2015 at 2:36 p.m., during an interview with CNA #2, she indicated that they always placed the metal ice scoop back into the plastic bag on the second shelf after using it to get ice from the cooler.</p> <p>08/19/2015 10:09 a.m., the DON was asked for a policy on passing ice.</p> <p>08/19/2015 10:13 a.m., the assistant director of nursing, ADON, indicated this facility did not have a policy for passing ice.</p> <p>3.1-18(a)</p>			