

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/04/2013
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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: March 25, 26, 27, 28, April 1, 2, 3, &amp; 4, 2013</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Survey team: Lara Richards, RN., TC Kathleen Vargas, RN. Heather Tuttle, RN. (3/25, 3/26, 4/3 &amp; 4/4/13) Cynthia Stramel, RN. (4/1-4/4/13)</p> <p>Census bed type: SNF/NF: 141 Residential: 48 Total: 189</p> <p>Census payor type: Medicare: 35 Medicaid: 70 Other: 84 Total: 189</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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	Quality review completed on April 9, 2013, by Janelyn Kulik, RN.			

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F000167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</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, interview and record review, the facility failed to ensure the Resident Council was aware of the availability and location of the latest survey results. This had the potential to affect all 141 residents residing at the facility.</p> <p>Findings include:</p> <p>Interview on 4/2/13 at 1:00 p.m., with the Resident Council President, indicated that she was not aware of where the survey results were located. She also indicated that she had never looked for nor seen the survey results.</p> <p>Review of the information posted on the wall near the West unit Nurses' station where required information was posted, indicated there was no notice of the survey location. The West Unit Manager indicated she</p>	F000167	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Resident council president was re-educated regarding where the survey results are located. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p>	04/26/2013	

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	<p>believed the survey results were located near the main entrance.</p> <p>At the Main Entrance, a notice was observed near the receptionist desk that indicated the survey results were in the Walnut Room.</p> <p>Interview with Activity Assistant #1 on 4/4/13 at 11:25 a.m., indicated that she reviewed the Resident Council minutes for the past year and she was unable to locate documentation that indicated the residents had been advised of where the survey results were located or that they had access to it.</p> <p>3.1-3(b)(1)</p>		<p>In-serviced held on 4/19/13 by Director of Nursing/designee regarding the following: 1. Survey results are located in the Walnut room Residents will be reminded of the location of the survey results in the next Resident Council meeting on 4/24/13 at 2pm by Activity staff representative/designee. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> At least quarterly at the Resident Council meeting, the Activity Director/designee will review the location of the survey results. Administration/designee will review the Resident council meeting minutes, and ensure at least quarterly the location of the survey results were reviewed. Administration will report to the Quality Assurance committee quarterly for the month the survey location was reviewed for 3 quarters. Thereafter, the Quality Assurance committee will determine if further reporting to the committee is needed.</p>		

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F000278 SS=B	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately completed related to urinary incontinence, oral status, end of life prognosis and height for 4 of 28 residents reviewed for accurate MDS</p>	F000278	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective action for resident <b>103</b> is as follows: MDS assessment dated 3/7/13 was modified on 3/2/13 The corrective action for resident <b>203</b> is as follows: MDS, assessment</p>	04/26/2013

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	<p>assessments. (Residents #16, #33, #103 and #203)</p> <p>Findings include:</p> <p>1. Resident #103 was observed on 3/27/13 at 8:43 a.m. in bed. The resident had no natural teeth in her mouth, she was edentulous.</p> <p>The resident's husband was interviewed on 3/25/13 at 11:17 a.m. He indicated the resident had no natural teeth.</p> <p>There was a nursing progress note, dated 3/7/13, written by MDS (Minimum Data Set) Coordinator #1, that indicated the resident was edentulous.</p> <p>The record for Resident #103 was reviewed on 3/27/13 at 9:32 a.m. There was a physician's order dated 11/17/12, that indicated, "admit to hospice."</p> <p>The form titled, "Hospice Physician/Medical Director Certification of Terminal Illness" with Resident #103's name, was reviewed. There was a statement that indicated, "I certify that the above named patient is terminally ill and has a life expectancy of six (6) months or less if</p>		<p>dated 2/13/13 was modified on 4/12/13 The corrective action for resident 16 is as follows: MDS, assessment dated 10/22/12 was modified on 4/1/13 The corrective action for resident 33 is as follows: MDS, assessments dated 11/27/12 and 12/18/12 were modified on 4/12/13 <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Current MDS's were reviewed by the MDs team and any sections coded inaccurately were amended. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-service held on 4/19/13 by Director of Nursing/designee regarding the following: 1. Recording in the Point of Care Record the level of continence for a resident every shift prior to leaving your shift 2. Restorative will evaluate the information and code the proper level on the MDS 3. Coding accurate dental information on the MDS 4. Coding accurate end of life information on the MDS 5. Coding accurate height on the MDS <b>How the corrective action(s) will be monitored to</b></p>				

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	<p>the illness runs its normal course." The form was signed by the Physician on 1/8/13.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, dated 3/7/13, was reviewed. The MDS indicated the resident's oral status was not assessed because staff was, "unable to examine oral cavity." The MDS also indicated the resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. The MDS indicated the resident was receiving hospice care.</p> <p>Interview with MDS Coordinator #1 on 3/27/13 at 10:45 a.m., indicated the MDS was inaccurately coded for dental status and for a life expectancy of less than 6 months.</p> <p>2. The record for Resident #203 was reviewed on 4/1/13 at 3:19 a.m. The Quarterly Minimum Data Set (MDS) assessment dated 2/13/13, was reviewed. The resident's height was coded as 61 inches.</p> <p>The Vital Sign Weight form indicated the resident's height was 4 foot 10 inches (58 inches) on 2/6/13.</p> <p>Interview with the Director of Nursing</p>		<p><b>ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Director of nursing/designee will audit 5 MDS's weekly to ensure the Dental, End of Life, Height, and Continance sections have been coded accurately. Audit tool attached. If any sections were coded incorrectly, the MDS will be modified at that point. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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	<p>on 4/2/13 at 9:56 a.m., indicated the MDS was inaccurately coded for the resident's height. She indicated the residents height was 4 foot 10 inches and should have been coded as 58 inches on the MDS.</p> <p>3. The record for Resident #16 was reviewed on 4/1/13 at 11:05 a.m. The Admission Minimum Data Set (MDS) assessment dated 10/22/12, was reviewed. The resident's urinary continence was coded as frequently incontinent.</p> <p>The form titled, "Point of Care History" was reviewed. The form was completed by the Certified Nursing Assistants and indicated the resident's bladder continence. It indicated the resident had been incontinent of urine 10/16/12, 10/17/12, 10/18/12, 10/19/12, 10/20/12, 10/21/12 and 10/22/12.</p> <p>Interview with the Restorative Nurse on 4/1/13 at 1:53 p.m., indicated the resident's MDS was inaccurately coded. She indicated the MDS should have been coded to indicate the resident was always incontinent of urine.</p> <p>4. The record for Resident #33 was reviewed on 4/2/13 at 3:23 p.m.</p>						

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	<p>The Readmission/return Minimum Data Set (MDS) assessment, dated 11/27/12, indicated the resident was always continent of urine. The Significant Change MDS assessment dated 12/18/12, indicated the resident was frequently incontinent of urine.</p> <p>The forms titled, "Point of Care History" for urinary continence were reviewed. They indicated the resident was incontinent of urine daily 11/14/12 through 11/27/12 and 12/5/13 through 12/18/12.</p> <p>On 4/3/13 at 10:14 a.m., the Restorative Nurse was interviewed. She indicated the resident's bladder continence was inaccurately coded on the Readmission/return MDS assessment, dated 11/27/12, and the Significant Change MDS assessment, dated 12/18/12. She indicated both assessments should have been coded as always incontinent of urine.</p> <p>3.1-31(d)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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, record review and interview, the facility failed to ensure the plan of care was followed as written related to the use of bed alarms for 1 of 3 residents reviewed for accidents of the 7 residents who met the criteria for accidents, completing an accurate joint mobility assessment for 1 of 3 residents reviewed for range of motion of the 28 residents who met the criteria for range of motion and the positioning of a foley catheter bag for 1 of 1 residents reviewed for foley catheters (Residents #47, #77, and #195)</p> <p>Findings include:</p> <p>1. The record for Resident #77 was reviewed on 4/2/13 at 2:08 p.m. The resident's diagnoses included, but were not limited to, fracture vertebrae-C2, history of fall, muscle weakness and difficulty walking.</p> <p>Review of the Fall Event report dated 3/5/13 at 6:04 a.m., indicated the resident was laying on the floor mattress next to the bed on her left</p>	F000282	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective action for resident 77 is as follows: Care card and care plan were reviewed to ensure all appropriate interventions in place. The corrective action for resident 47 is as follows: Joint Mobility observation was updated on 4/12/13. Care plan updated on 4/12/13. The corrective action for resident 195 is as follows: Dignity bag cover was provided and foley placed in bag. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. Residents who have fall interventions in place were reviewed to ensure interventions appropriate and present. All residents who have foleys catheters were provided dignity bags if one was not already present. Current Joint Mobility Observations were reviewed to</p>	04/26/2013			

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	<p>side. Her entire body was on the mattress. The resident was wearing non-skid socks at the time and her bedside mat was in use. There was no documentation indicating if the residents bed alarm was in use as well as her bed bolsters.</p> <p>Review of the plan of care dated 10/6/11 which had been reviewed February 2013, indicated the resident was at risk for falling related to history of falls. The interventions included, but were not limited to, bed alarm and bolsters to bed.</p> <p>Interview with the Restorative Director and the Nurse Consultant on 4/4/13 at 9:50 a.m., indicated there was no documentation to indicate if the resident's bed alarm and bolsters were in place at the time the resident rolled out of bed on 3/5/13. The Restorative Director indicated there was no indication if a bed alarm was in place when the facility's internal investigation was completed. The investigation did indicate the resident's bed bolsters were replaced.</p> <p>2. On 3/27/13 at 9:00 a.m., Resident #47 was seated in her wheelchair in the Main Dining room. The resident was observed to have limited range of motion (ROM) to the third and fourth</p>		<p>ensure accuracy. Joint Mobility Observations were updated if the resident assessment was different than what was coded. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service was completed on 4/12/13 by Assistant Director of Nursing (former Restorative Nurse) with the Restorative nurse. Education included how to perform the Joint Mobility observation, how to interpret the observations, and code them appropriately on the form.</p> <p>In-service held on 4/19/13 by Director of Nursing/designee regarding the following: 1. How to perform Joint Mobility observation and record observations 2. Reading the care card to ensure appropriate interventions in place 3. Documenting observations after a fall 4. Placing foley drainage bags in dignity bags to prevent touching floor 5. Location of where extra dignity bag covers are stored <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Guardian Angel rounds will be made by department managers weekly on various shifts to ensure residents with foleys have dignity bag covers and bed/chair alarms in</p>				

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	<p>fingers on both of her hands.</p> <p>The record for Resident #47 was reviewed on 4/1/13 at 11:40 a.m. Review of the Joint Mobility assessments dated 10/26/12 and 1/17/13, indicated Left hand/fingers-left palm up, fingers spread, measure movement to close and open was within normal limits. Right hand/fingers-right palm up, fingers spread, measure movement to close and open was within normal limits.</p> <p>The 11/30/12 Joint Mobility assessment, indicated left hand/fingers and right hand/fingers moderate/severe limitation (26% to 50% available ROM).</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/17/13, indicated the resident had functional limitation in ROM with impairment on both sides of the upper and lower extremity.</p> <p>The 11/30/12 plan of care, indicated the resident was limited in voluntary movement to bilateral upper and lower extremities related to paralysis agitans, joint stiffness, decreased ROM and dexterity. The approaches included, but were not limited to,</p>		<p>place. If a resident is observed without a dignity bag cover, one will be obtained immediately and foley drainage bag put inside the cover. If an alarm is not in place or working, one will be obtained immediately. Audit tool attached.</p> <p>Assistant Director of Nursing (ADON)/designee will review the Joint Mobility observation for 5 residents weekly to ensure accurate information coded. If observations are different, ADON/designee will meet with the nurse to review findings and/or re-educate how to perform and complete observation. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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	<p>observe for any changes in condition of resident's skin or any increase in stiffness to the affected joint and the Restorative Nurse was to complete a Joint Mobility evaluation at least quarterly and as needed.</p> <p>Interview with the Restorative Director on 4/3/13 at 1:15 p.m., indicated the resident's Joint Mobility assessment completed in January 2013 and October 2012 were inaccurate related to hand/finger range of motion. She indicated that she had not completed the forms and she would inservice staff on how to complete the form.</p> <p>3. Resident #195 was observed on 3/27/13 at 8:43 a.m. The resident was in a low bed, and he had a urinary catheter. The catheter drainage bag was touching the floor, it was not placed in a dignity bag (an opaque protective pouch).</p> <p>The resident was observed on 3/28/13 at 8:15 a.m. He was in a low bed, the catheter drainage bag was touching the floor, it was not in a dignity bag.</p> <p>On 4/1/13 at 9:45 a.m., the resident was observed in bed. The urinary drainage bag was touching the floor. The urinary drainage bag was not in a</p>				

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	<p>dignity bag.</p> <p>The record for Resident #195 was reviewed on 3/27/13 at 1:30 p.m. The resident had diagnoses that included, but were not limited to, multiple sclerosis, urinary obstruction and urinary tract infection. The resident had a supra pubic catheter (a catheter inserted through the abdominal wall into the bladder).</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/22/13, indicated the resident had an indwelling catheter.</p> <p>A care plan that was dated 11/9/12, indicated: "Resident requires a suprapubic catheter Goal: Resident will not exhibit obstruction, complications from current infection, dislodgement of catheter, bowel perforation or trauma secondary to catheter manipulation." The approaches included: "-avoid obstructions in the drainage -catheter care as ordered -do not allow tubing or any part of the drainage system to touch the floor. -store collection bag inside a protective, dignity pouch. "</p> <p>Interview with the Director of Nursing</p>						

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	<p>on 3/14/13 at 12:15 p.m., indicated the resident's urinary drainage bag should not have been touching the floor and should have been placed in a dignity bag as indicated in the resident's plan of care.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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 the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to administer a medication used to reduce the need for blood transfusions (Aranesp) and failed to obtain laboratory tests that assessed the resident's anemic status (hemoglobin level) for 1 of 3 residents reviewed for hospitalization of the 11 residents who met the criteria for hospitalization. (Resident #33)</p> <p>Findings include:</p> <p>The record for Resident #33 was reviewed on 4/2/13 at 3:23 p.m. The resident had diagnoses that included, but were not limited to, adult failure to thrive, anemia, dementia and myelodysplastic syndrome (an anemia that requires frequent blood transfusions).</p> <p>The resident was readmitted to the facility on 2/20/13. He had been hospitalized on 1/14/13 for a non-healing ulcer and subsequent</p>	F000309	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective action for resident <b>33</b> is as follows:</p> <p>Aranesp was discontinued on 3/20/13. Resident was placed on Hospice 3/18/13. Resident expired on 4/7/13</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice.</p>	04/26/2013			

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	<p>above the knee amputation on 1/17/13.</p> <p>The readmission Physician Order Sheet, dated 2/20/13, was reviewed. The resident had orders for Aranesp (a medication used to treat anemia by increasing hemoglobin levels) 40 mcg (micrograms) on Wednesdays, fax HGB (hemoglobin-a protein in the red blood cell which can indicate anemia) levels to pharmacy prior to injection. The Aranesp was to be administered on Wednesday 2/27/13.</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the Aranesp was to be administered weekly after hemoglobin levels were obtained and faxed to the pharmacy</p> <p>Review of the lab results indicated a CBC (complete blood count) had been obtained on 2/26/13. The results of the CBC indicated the resident's HGB was 7.8 (alert level). The normal range for hemoglobin was 14.0-18.1.</p> <p>There was a progress note dated 2/26/13 at 1:31 p.m., that indicated the results of the CBC were reported to the resident's physician.</p> <p>Review of the Medication Flowsheet</p>		<p>All residents on Aranesp were audited for required labs and administration of the medication per physician orders.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/19/13 by Director of Nursing/designee regarding the following:</p> <ol style="list-style-type: none"> <li>Necessary lab tests for Aranesp medication</li> <li>Faxing lab results to physician and pharmacy</li> <li>Notifying pharmacy if medication not available</li> <li>Administering medication per physician order</li> <li>Obtaining Prior Authorization if required by pharmacy</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into</b></p>				

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	<p>generated on 2/20/13, indicated there was no evidence the Aranesp was given on Wednesday, 2/27/13, as ordered.</p> <p>There was a progress note dated 2/27/13 at 3:00 p.m., that indicated, "resident's Aranesp was not given because it was not sent from pharmacy. Pharmacy said they need current labs showing hemoglobin levels before they sent (sic) it. MD (Physician) was notified and he said to change the date to tomorrow and fax labs over to Pharmacy. Family made aware."</p> <p>There was a physician order dated 2/27/13, that indicated, "Aranesp 40 mcg/ml (microgram/milliliter) amount to administer 40 mcg, once a day on Thursday. Please fax HGB levels to Pharmacy prior to giving injection."</p> <p>The Medication Flowsheet generated on 2/27/13 was reviewed. There was an entry on the form that indicated, "labs faxed 2/27/13." There was no evidence that the Aranesp was given on Thursday, 2/28/13.</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the Aranesp was not administered on 2/27/13 or on 2/28/13.</p>		<p>place;</p> <p>Unit Managers/designee will audit all residents on Aranesp weekly to determine if labs were drawn and medication administered by physician orders. Audit tool attached.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	

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	<p>Review of the Medication Flowsheet generated on 2/28/13, indicated, "Aranesp 40 mcg/ml amount to administer 40 mcg once a day on Thurs, Please fax HGB levels to Pharmacy prior to giving injection." There was no evidence the Aranesp was administered as ordered on Thursday 3/7/13.</p> <p>Review of the lab results indicated there was no evidence the HGB was obtained on 3/7/13.</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the resident did not receive the Aranesp as ordered on 3/7/13 and he did not have a lab drawn to assess the hemoglobin level.</p> <p>Continued review of the record indicated a CBC was obtained on 3/12/13, the results indicated the HGB was 6.1, a critical level, and the RBC (red blood count) was 2.5, a low level, normal RBC range was 4.70-6.10.</p> <p>There was a progress note dated 3/12/13 at 3:51 p.m., that indicated, "Called (Hematologist's name) office in regards to HGB 6.1. Doctor not in nurse will paged Dr. [sic]." The next</p>						

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	<p>entry was dated, 3/12/13 at 4:00 p.m., and indicated, "spoke with (Attending Physician's name) regarding critical lab results, send to hospital for tx (treatment)."</p> <p>The hospital History and Physical dated 3/12/13 indicated, "Chief Complaint: Severe anemia with hemoglobin of 6.1 at the nursing home today and worsening of shortness of breath. History of Present Illness: This 90-year-old white male patient, a nursing home resident at (Name of Facility), was admitted through the emergency room. CBC test was done again and hemoglobin was 5.9, patient is getting admitted for blood transfusion. Recently the patient was hospitalized to the hospital north campus and then had amputation of the left leg above the knee because of chronic nonhealing ulcer of the heel, and then he stayed at (Name of Hospital) for a while for physical therapy and also IV (intravenous) antibiotics for the osteomyelitis on the left ischium, and the patient was discharged to (Facility name) on 02/20/2012. During the hospitalization, the patient was evaluated for his anemia and pancytopenia (abnormal decrease blood cells), and a bone marrow test was done and that test was</p>				

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	<p>compatible with myelodysplastic syndrome, and the recommendation was conservative treatment of intermittent blood transfusion. Today he was found to have a hemoglobin of 6.1 and was transferred to our hospital."</p> <p>An entry by the Physician dated 3/13/13, indicated, "transfusion of packed cells being done. Plan to discharge back to (Facility name) today after transfusion."</p> <p>Interview with the Director of Nursing on 4/3/13 at 2:20 p.m., indicated the resident had a history of requiring blood transfusions due to the diagnosis of myelodysplastic syndrome. She also indicated the resident had a physician's order for Aranesp weekly. She indicated the pharmacy would not send the Aranesp without a HGB level. She indicated the resident did not receive the Aranesp after readmission on 2/20/13 through 3/13/13. She indicated the weekly hemoglobin level was not obtained on 3/7/13.</p> <p>Review of the 2010 Nursing Spectrum Drug Handbook indicated, "Aranesp stimulates erythropoiesis (formation of red blood cells) in bone marrow, increasing red blood cell production.</p>						

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	<p>The medication is used to treat anemia. The onset of the medication is 2-6 weeks." It also indicated, "Patient monitoring -assess hemoglobin concentration before starting therapy and then weekly during therapy."</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the Pharmacy did not send the Aranesp because a prior authorization form was not completed by the attending physician. She also indicated Aranesp was a medication that was not covered by insurance without a written prior authorization from the physician.</p> <p>A progress note dated 3/1/13 at 11:53 p.m., indicated, "Awaiting Aranesp from (Pharmacy name). (Physician's name) needs to call pharmacy for authorization of Aranesp. Endorsed to night nurse to remind (Physician's name) in the a.m. about Aranesp."</p> <p>Interview with LPN #3 on 4/4/13 at 10:52 a.m., indicated he had contacted the Physician on 3/1/13 and twice on 3/7/13 regarding the need to complete the prior authorization form so the Pharmacy would send the Aranesp.</p>			

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	<p>Interview with the Director of Nursing on 4/4/13 at 10:15 a.m., indicated there should have been more attempts to notify the Physician of the need for the prior authorization to obtain the medication Aranesp or of the need to alter the treatment. She indicated the resident should have received the Aranesp as ordered and the hemoglobin testing as required.</p> <p>3.1-37(a)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure interventions were provided to prevent urinary tract infections for residents with indwelling urinary catheters, related to a urinary drainage bag on the floor for 1 of 1 residents reviewed for indwelling catheters. (Resident #195)</p> <p>Findings include:</p> <p>Resident #195 was observed on 3/27/13 at 8:43 a.m.. The resident was in a low bed, he had a urinary catheter. The catheter drainage bag was touching the floor, it was not placed in a dignity bag (an opaque bag) .</p> <p>The resident was observed on 3/28/13 at 8:15 a.m. He was in a low bed, the catheter drainage bag was</p>	F000315	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective action for resident <b>195</b> is as follows: Dignity bag cover was provided and foley placed in bag. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. All residents who have foleys catheters were provided dignity bags if one was not already present. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/19/13 by Director of Nursing/designee regarding the following: 1.</p>	04/26/2013			

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	<p>touching the floor, it was not in a dignity bag.</p> <p>On 4/1/13 at 9:45 a.m., the resident was observed in bed. The urinary drainage bag was touching the floor. The urinary drainage bag was not in a dignity bag.</p> <p>The record for Resident #195 was reviewed on 3/27/13 at 1:30 p.m. The resident had diagnoses that included, but were not limited to, multiple sclerosis, urinary obstruction and urinary tract infection. The resident had a supra pubic catheter (a catheter inserted through the abdominal wall into the bladder).</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/22/13, indicated the resident had an indwelling catheter.</p> <p>The resident had a history of urinary tract infections. There was a urine culture dated 2/23/13, that indicated there was greater than 100,000 colonies of Proteus mirabilis (a type of bacteria) in the urine which indicated a urinary tract infection.</p> <p>There was a Physician Order, dated 2/26/13, that indicated, "Levaquin (an antibiotic) 250 mg (milligrams) orally</p>		<p>Placing foley drainage bags in dignity bag covers to prevent touching the floor 2. Location of where extra dignity bag covers are stored <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Guardian Angel rounds will be made by department managers weekly on various shifts to ensure residents with foleys have dignity bag covers. If a resident is observed without a dignity bag cover, one will be obtained immediately and foley drainage bag put in cover. Audit tool Attached. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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	<p>daily for 7 days for urinary tract infection."</p> <p>A care plan dated 11/9/12, indicated: "Resident requires a suprapubic catheter Goal: Resident will not exhibit obstruction, complications from current infection, dislodgement of catheter, bowel perforation or trauma secondary to catheter manipulation." The approaches included: "-avoid obstructions in the drainage -catheter care as ordered -do not allow tubing or any part of the drainage system to touch the floor. -store collection bag inside a protective cover. "</p> <p>The Policy titled, "Catheter Care, Urinary," dated September 2005, was provided by the Director of Nursing on 4/1/13. She indicated the policy was current. The policy indicated, "-be sure the catheter tubing and the drainage bag are kept off the floor."</p> <p>Interview with the Director of Nursing on 4/3/13 at 12:15 p.m., indicated the resident's urinary drainage bag should not have been touching the floor.</p> <p>3.1-41(a)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311			
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a bed alarm was in use at the time of a fall for a resident who was a fall risk for 1 of 3 residents reviewed for accidents of the 7 residents who met the criteria for accidents. (Resident #77)</p> <p>Findings include:</p> <p>The record for Resident #77 was reviewed on 4/2/13 at 2:08 p.m. The resident's diagnoses included, but were not limited to, fracture vertebrae-C2, history of fall, muscle weakness and difficulty walking.</p> <p>Review of the Fall Event report dated 3/5/13 at 6:04 a.m., indicated the resident was laying on the floor mattress next to the bed on her left side. Her entire body was on the mattress. The resident was wearing non-skid socks at the time and her bedside mat was in use. There was no documentation indicating if the residents bed alarm was in use as</p>	F000323	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective action for resident 77 is as follows:</p> <p>Care card and care plan were reviewed to ensure all appropriate interventions in place.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. Residents who have fall interventions in place were reviewed to ensure interventions</p>	04/26/2013			

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	<p>well as her bed bolsters.</p> <p>Review of the plan of care dated 10/6/11 which had been reviewed February 2013, indicated the resident was at risk for falling related to history of falls. The interventions included, but were not limited to, bed alarm and bolsters to bed.</p> <p>The resident had previous falls on 12/13/12 which resulted in a fracture and on 1/11/13.</p> <p>Review of the Fall Risk assessment dated 3/5/13 indicated the resident scored "21" a high risk and to continue the current plan of care.</p> <p>Interview with the Restorative Director and the Nurse Consultant on 4/4/13 at 9:50 a.m., indicated there was no documentation to indicate if the resident's bed alarm and bolsters were in place at the time the resident rolled out of bed on 3/5/13. The Restorative Director indicated there was no indication if a bed alarm was in place when the facility's internal investigation was completed. The investigation did indicate the resident's bed bolsters were replaced.</p> <p>3.1-45(a)(2)</p>		<p>appropriate and in place.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/19/13 by Director of Nursing/designee regarding the following:</p> <ol style="list-style-type: none"> <li>1. Reading the care card to ensure appropriate interventions in place</li> <li>2. Documenting observations after a fall</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Guardian Angel rounds will be made by department managers weekly on various shifts to ensure residents with alarms are in place and working. If an alarm is not in place or working, one will be obtained immediately. Audit tool attached.</p>				

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			A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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F000332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% was maintained for 3 of 13 residents observed during medication pass. Five errors were observed during 26 opportunities for error during medication administration. This resulted in a medication error rate of 19%. (Residents #172, #129, and #155)</p> <p>Findings include:</p> <p>1. On 4/2/13 at 8:53 a.m., LPN #2 was observed preparing medications for Resident #129. The LPN removed 1 Feosol (ferrous sulfate, iron supplement) 325 milligrams (mg) tablet, 1 Klor Con (potassium supplement) 10 MeQ (milliequivalents) tablet, 1 Lasix (a water pill) tablet, and 1 Gabapentin (a medication used to treat pain and neuropathy) capsule, and Visine eye drops. She crushed the 3 tablets and opened the capsule and mixed it with applesauce. The medication was then administered to the resident.</p>	F000332	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective action for resident <b>129</b> is as follows:  The Ferrous Sulfate and Potassium were changed to liquid form.</p> <p>The corrective action for resident <b>172</b> is as follows:  The Wellbutrin SR was changed to Wellbutrin.</p> <p>The corrective action for resident <b>155</b> is as follows:  Insulin orders and dietary card reviewed and updated.</p> <p><b>How the facility will identify other residents having the</b></p>	04/26/2013			

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	<p>The record for Resident #129 was reviewed on 4/2/13 at 11:30 a.m. Review of the April 2013 Physicians' Order Summary (POS), indicated "may crush appropriate medications when needed and place into appropriate food substance unless contraindicated".</p> <p>On 4/2/13 at 3:00 p.m., the Director of Nursing provided a copy of "Medications Not To Be Crushed." The list indicated Klor Con and several name brands of ferrous sulfate. The name brand Feosol was not on the list. The Director of Nursing did not indicate if she agreed if the Feosol medication should not be crushed. The Do not Crush list indicated Klor Con was a time released medication.</p> <p>2. On 4/1/13 at 1:31 p.m., LPN #3 was observed preparing medications for Resident #172. The LPN removed 1 tablet of Wellbutrin SR (an antidepressant) and 1 tablet of Baclofen (a muscle relaxer). The medications were crushed and mixed into applesauce, then administered to the resident.</p> <p>Interview with LPN #3 on 4/3/13 at 12:45 p.m., indicated that Resident</p>		<p><b>potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. Residents who require their medications crushed were reviewed to identify other medications which require conversion. Residents who receive insulin were reviewed and orders updated as needed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/19/13 by Director of Nursing/designee regarding the following:</p> <ol style="list-style-type: none"> <li>"Do Not Crush" list located in front of Medication Administration Record.</li> <li>If the resident must have their medications crushed and there is a medication that is not appropriate, the physician should be contacted for a substitution.</li> </ol>	

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	<p>#172's medications were to be crushed prior to administration. He was not aware that Wellbutrin SR was on the "Medications Not To Be Crushed" list and indicated he would notify the pharmacy.</p> <p>The record for Resident #172 was reviewed on 4/2/13 at 11:40 a.m. Review of the April 2013 Physician's Order Summary (POS), indicated "May crush medications unless contraindicated and give in food substance".</p> <p>On 4/2/13 at 3:00 p.m., the Director of Nursing provided a copy of "Medications Not To Be Crushed", included on this list was Wellbutrin SR. The key indicated this was a time released medication.</p> <p>3. On 4/1/13 at 11:36 a.m., LPN #1 was observed performing a glucometer test (test to determine blood sugar level) and prepare insulin for Resident #155. The resident's blood sugar was 387. The LPN proceeded to administer the scheduled dose of 4 units of Novolog (short acting insulin). The LPN then returned to the medication cart for additional insulin. The Physician Orders required an additional 8 units of Novolog per the sliding scale. The</p>		<p>3. An order must be present prior to crushing their medications.</p> <p>4. Insulin should be given within a reasonable amount of time of their meal time to prevent any hypoglycemic reactions.</p> <p>5. After the tray cart has been passed, staff members are to ensure all residents on the unit have a tray. If a resident did not receive a tray, the staff member will alert dietary immediately.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Director of nursing/designee will audit 5 residents weekly, who require their medications crushed, to determine if current medications are crushable. If any are noted on the "Do not Crush" list, the physician will be contacted for alternative. Audit tool attached.</p> <p>Director of nursing/designee will audit twice weekly, on various meals, to ensure the residents on</p>				

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	<p>resident received the additional 8 units of Novolog at 11:40 a.m., for a total of 12 units of Novolog prior to lunch.</p> <p>At 12:45 p.m., the resident was observed in bed with his eyes closed. There was no meal tray in his room and staff were picking up lunch trays from the remainder of the unit. Upon inquiry, it was determined the resident had not received his lunch. The CNA went to the dining room to obtain a lunch tray for the resident.</p> <p>At 1:00 p.m., the West Unit Manager was asked if there was a policy regarding a diabetic who received 12 units of Novolog over an hour ago and had not eaten yet. She indicated, "wise nursing judgment" would involve obtaining another blood sugar level, which she then instructed LPN # 1 to do. At 1:09 p.m., a CNA was sitting at resident's bedside feeding him lunch. The resident's blood glucose level was 399 and the LPN indicated that she had paged the Physician.</p> <p>The record for Resident #155 was reviewed on 4/2/13 at 11:55 a.m. The resident's diagnoses included, but was not limited to, Type 2 Diabetes. Review of the April 2013 Physician's</p>		<p>the unit received a meal tray. If a resident is found without a meal tray, dietary will be alerted immediately.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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	<p>Order Summary (POS), indicated the resident was to receive 4 units of Novolog insulin TID AC (three times a day before meals) and Novolog sliding scale TID AC and HS (three times a day before meals and bedtime). The Sliding scale parameters were as follows: 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units. Call MD for less than 60 or greater than 400.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated under guidelines for Novolog administration: "Be aware that insulin is a high alert drug" and "Give by subcutaneous (injection) route only 5 to 10 minutes before a meal".</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F000333 SS=D	<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 observation, record review and interview, the facility failed to ensure the residents were free of significant medication errors, related to the failure to administer a medication used to reduce the need for blood transfusions (Aranesp) for 1 of 3 residents reviewed for hospitalization of the 11 residents who met the criteria for hospitalization. The facility also failed to ensure insulin was administered at the appropriate time for 1 of 1 resident observed receiving insulin during medication administration. (Resident #33 and Resident #155)</p> <p>Findings include:</p> <p>1. The record for Resident #33 was reviewed on 4/2/13 at 3:23 p.m. The resident had diagnoses that included, but were not limited to, adult failure to thrive, anemia, dementia and myelodysplastic syndrome (an anemia that requires frequent blood transfusions).</p> <p>The Physician Order Sheet, dated 2/20/13, was reviewed. The resident had orders for Aranesp (a medication</p>	F000333	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective action for resident 33 is as follows:</p> <p>Aranesp was discontinued on 3/20/13. Resident was placed on Hospice 3/18/13. Resident expired on 4/7/13.</p> <p>The corrective action for resident 155 is as follows:</p> <p>Insulin orders and dietary card reviewed and updated.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p>	04/26/2013	

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	<p>used to treat anemia by increasing hemoglobin levels) 40 mcg (micrograms) on Wednesdays, fax HGB (hemoglobin-a protein in the red blood cell which can indicate anemia) levels to pharmacy prior to injection. The Aranesp was to be administered on Wednesday 2/27/13.</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the Aranesp was to be administered weekly after hemoglobin levels were obtained and faxed to the pharmacy</p> <p>Review of the lab results indicated a CBC (complete blood count) had been obtained on 2/26/13. The results of the CBC indicated the resident's HGB was 7.8 (alert level). The normal range for hemoglobin was 14.0-18.1.</p> <p>There was a progress note dated 2/26/13 at 1:31 p.m., that indicated the results of the CBC were reported to the resident's physician.</p> <p>Review of the Medication Flowsheet generated on 2/20/13, indicated there was no evidence the Aranesp was given on Wednesday, 2/27/13, as ordered.</p> <p>There was a progress note dated</p>		<p>All facility residents have the potential to be affected by the same alleged deficient practice. Residents on Aranesp were audited for required labs and administration of medication per physician orders. Residents who receive insulin were reviewed and orders updated as needed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/19/13 by Director of Nursing/designee regarding the following:</p> <ol style="list-style-type: none"> <li>Necessary lab tests for Aranesp medication</li> <li>Faxing lab results to physician and pharmacy</li> <li>Notifying pharmacy if medication not available</li> <li>Administering medication per physician order</li> <li>Obtaining Prior Authorization if required by pharmacy</li> <li>Insulin should be given within a reasonable amount of</li> </ol>				

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	<p>2/27/13 at 3:00 p.m., that indicated, "resident's Aranesp was not given because it was not sent from pharmacy. Pharmacy said they need current labs showing hemoglobin levels before they sent (sic) it. MD (Physician) was notified and he said to change the date to tomorrow and fax labs over to Pharmacy. Family made aware."</p> <p>There was a physician order dated 2/27/13, that indicated, "Aranesp 40 mcg/ml (microgram/milliliter) amount to administer 40 mcg, once a day on Thursday. Please fax HGB levels to Pharmacy prior to giving injection."</p> <p>The Medication Flowsheet generated on 2/27/13, was reviewed. There was an entry on the form that indicated, "labs faxed 2/27/13." There was no evidence that the Aranesp was given on Thursday, 2/28/13.</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the Aranesp was not administered on 2/27/13 or on 2/28/13.</p> <p>Review of the Medication Flowsheet generated on 2/28/13, indicated, "Aranesp 40 mcg/ml amount to administer 40 mcg once a day on Thurs, Please fax HGB levels to</p>		<p>time of their meal time to prevent any hypoglycemic reactions.</p> <p>7. After the tray cart has been passed, staff members are to ensure all residents on the unit have a tray. If a resident did not receive a tray, the staff member will alert dietary immediately</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Unit Managers/designee will audit all residents on Aranesp weekly for to determine if labs were drawn and medication administered by physician orders. Audit tool attached.</p> <p>Director of nursing/designee will audit twice weekly, on various meals, to ensure the residents on the unit received a meal tray. If a resident is found without a meal tray, dietary will be alerted immediately.</p> <p>A summary of the audits will be presented to the Quality</p>		

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	<p>Pharmacy prior to giving injection." There was no evidence the Aranesp was administered as ordered on Thursday 3/7/13.</p> <p>Review of the lab results indicated there was no evidence the HGB was obtained on 3/7/13.</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the resident did not receive the Aranesp as ordered on 3/7/13 and he did not have a lab drawn to assess the hemoglobin level.</p> <p>Interview with the Director of Nursing on 4/3/13 at 2:20 p.m., indicated the resident had a physician's order for Aranesp weekly. She indicated the pharmacy would not send the Aranesp without a HGB level. She indicated the resident did not receive the Aranesp after readmission on 2/20/13 through 3/13/13. She indicated the weekly hemoglobin level was not obtained on 3/7/13.</p> <p>Review of the 2010 Nursing Spectrum Drug Handbook indicated, "Aranesp stimulates erythropoiesis (formation of red blood cells) in bone marrow, increasing red blood cell production. The medication is used to treat anemia. The onset of the medication</p>		Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.				

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	<p>is 2-6 weeks." It also indicated, "Patient monitoring -assess hemoglobin concentration before starting therapy and then weekly during therapy."</p> <p>Interview with the Director of Nursing on 4/4/13 at 9:10 a.m., indicated the Pharmacy did not send the Aranesp because a prior authorization form was not completed by the attending physician. She also indicated Aranesp was a medication that was not covered by insurance without a written prior authorization from the physician.</p> <p>A progress note dated 3/1/13 at 11:53 p.m., indicated, "Awaiting Aranesp from (Pharmacy name). (Physician's name) needs to call pharmacy for authorization of Aranesp. Endorsed to night nurse to remind (Physician's name) in the a.m. about Aranesp."</p> <p>Interview with LPN #3 on 4/4/13 at 10:52 a.m., indicated he had contacted the Physician on 3/1/13 and twice on 3/7/13 regarding the need to complete the prior authorization form so the Pharmacy would send the Aranesp.</p> <p>Interview with the Director of Nursing on 4/4/13 at 10:15 a.m., indicated</p>			

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	<p>there should have been more attempts to notify the Physician of the need for the prior authorization to obtain the medication Aranesp or of the need to alter the treatment. She indicated the resident should have received the Aranesp as ordered.</p> <p>2. On 4/1/13 at 11:36 a.m., LPN #1 was observed performing a glucometer test (test to determine blood sugar level) and prepare insulin for Resident #155. The resident's blood sugar was 387. The LPN proceeded to administer the scheduled dose of 4 units of Novolog (short acting insulin). The LPN then returned to the medication cart for additional insulin. The Physician Orders required an additional 8 units of Novolog per the sliding scale. The resident received the additional 8 units of Novolog at 11:40 a.m., for a total of 12 units of Novolog prior to lunch.</p> <p>At 12:45 p.m., the resident was observed in bed with his eyes closed. There was no meal tray in his room and staff were picking up lunch trays from the remainder of the unit. Upon inquiry, it was determined the resident had not received his lunch. The CNA went to the dining room to obtain a lunch tray for the resident.</p>				

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	<p>At 1:00 p.m., the West Unit Manager was asked if there was a policy regarding a diabetic who received 12 units of Novolog over an hour ago and had not eaten yet. She indicated, "wise nursing judgment" would involve obtaining another blood sugar level, which she then instructed LPN # 1 to do. At 1:09 p.m., a CNA was sitting at resident's bedside feeding him lunch. The resident's blood glucose level was 399 and the LPN indicated that she had paged the Physician.</p> <p>The record for Resident #155 was reviewed on 4/2/13 at 11:55 a.m. The resident's diagnoses included, but was not limited to, Type 2 Diabetes. Review of the April 2013 Physician's Order Summary (POS), indicated the resident was to receive 4 units of Novolog insulin TID AC (three times a day before meals) and Novolog sliding scale TID AC and HS (three times a day before meals and bedtime). The Sliding scale parameters were as follows: 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units. Call MD for less than 60 or greater than 400.</p> <p>The 2010 Nursing Spectrum Drug</p>			

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	<p>Handbook indicated under guidelines for Novolog administration: "Be aware that insulin is a high alert drug" and "Give by subcutaneous (injection) route only 5 to 10 minutes before a meal".</p> <p>3.1-48(c)(2) 3.1-25(b)(9)</p>			

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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 lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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, record review and interview, the facility failed to</p>	F000441	What corrective action(s) will	04/26/2013			

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	<p>maintain a sanitary and comfortable environment related to improper storage of a bedpan and graduated containers in 3 shared resident bathrooms, this had the potential to affect 6 of 6 residents residing in these rooms. The facility also failed to ensure gloves were worn while administering injections to 1 of 2 residents. (Resident #140)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 3/25/13 at 3:13 p.m., a plastic container used for urine measurement was observed in the bathroom on the back of the toilet in Room 182. The container was not covered with a plastic bag. This room was shared by 2 residents.</li> <li>On 3/26/13 at 8:45 a.m., a bedpan was observed in the bathroom of Room 179 on the back of the toilet. The bedpan was not covered with a plastic bag. This room was shared by 2 residents.</li> <li>On 3/26/13 at 12:05 p.m., a plastic container used for urine measurement was observed in the bathroom of Room 115 on the back of the toilet. The container was not covered with a plastic bag. This room was shared by 2 residents.</li> </ol>		<p><b>be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective action for resident 140 is as follows:</p> <p>Resident had no negative outcome related to gloves not being worn when an injection was administered.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. Room rounds were completed to ensure urinals and/or bed pans were properly stored.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p>				

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	<p>Interview with the Director of Nursing on 4/4/13 at 10:30 a.m., indicated bedpans and urinals should be wrapped in plastic and stored in the residents' bottom drawer.</p> <p>On 4/4/13 at 8:00 a.m., the Bedside Equipment Disinfection policy and procedure was reviewed. The current policy indicated the following:</p> <p>"1. Resident bedside equipment will remain in a clean condition at all times and be stored in the lower portion of the night stand...</p> <p>9. Bedside equipment consists of the following items: bedpans, urinals, wash basins, emesis basins, bedside commode...</p> <p>NOTE: Bedside equipment may not be stored in a shared bathroom or commingled with other resident supplies."</p> <p>4. On 4/1/13 at 11:18 a.m., LPN #1 was observed to obtain Resident #140's blood sugar. The LPN was observed to apply a pair of gloves and obtain the blood sugar level through a finger stick blood sample. She then proceeded to remove the gloves and wash her hands. The LPN retrieved the prepared syringe which contained the resident's</p>		<p>In-service held on 4/19/13 by Director of Nursing/designee regarding the following:</p> <ol style="list-style-type: none"> <li>1. Appropriate storage of urinals/bed pans</li> <li>2. Appropriate infection control measures when administering an injection</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Guardian angel rounds will be completed weekly on various shifts by department managers to ensure proper storage of urinals/bed pans. If found, the item will be stored per proper procedure immediately.</p> <p>Director of nursing/designee will audit 5 residents weekly, who require insulin injections, to ensure gloves are worn during administration. Audit tool attached.</p>		

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	<p>scheduled insulin, and gave the resident the injection without applying gloves. She then left the room to obtain additional insulin.</p> <p>Interview with the LPN at this time, indicated that she had forgotten to use gloves during the first injection.</p> <p>Review of the 1/1/05 Standard Precautions Policy provided by the Director of Nursing indicated "When administering medications or treatments, Standard Precautions will be used as appropriate. Gloves will be worn when contact with the resident is possible, i.e. injections...."</p> <p>3.1-19(f)</p>		<p>A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a sanitary environment related to soiled oven doors, soiled oven hood and soiled wheels on a baker's rack in 1 of 1 kitchen, soiled bathroom floors, soiled cove bases and soiled caulking, lime buildup on bathroom faucets and marred doors for 2 of 2 units. This deficient practice had the potential to effect 138 of 141 residents who consumed food prepared in the facility's kitchen and for 141 of 141 residents who resided in the facility. (The Main Kitchen, East Unit and West Unit)</p> <p>Findings include:</p> <p>1. The Kitchen Sanitation Tour was completed on 4/2/13 at 10:15 a.m., with the Assistant Dietary Manager and the Dietary Manager. The following was observed:</p> <p>a. Four of four convention oven doors had a yellow buildup of grease. The doors were in need of cleaning.</p> <p>b. The outside edge of the oven hood</p>	F000465	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions were as follows: Convection oven doors and oven hood were cleaned and tasks were added to A.M. and P.M. Cook cleaning schedule. Baker's rack wheels were changed. Baker's rack wheels were added to Prep Cook weekly cleaning schedule. Floor tile next to entertainment center, bathroom floor tile and cove base in bathroom were cleaned in room 105. Bathroom floor tile was replaced in room 103. Bathroom faucet in room 102 was replaced. Caulk was replaced in the bathroom, and floor tile replaced in room 101. Soap dispensers mounted on the wall were cleaned and new brackets and pumps were purchased. Wheel chair scale was relocated and room closed. Maintenance Supervisor/designee has the only key. Caulk and floor tile were replaced in the bathroom of room 152. The shower tub was cleaned. Protective vinyl kick plate installed on door to cover and repel scratches in room 188. Wheelchair scale and sit to stand</p>	04/26/2013			

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	<p>had a buildup of yellow grease and was in need of cleaning.</p> <p>c. Four of four wheels of the dessert bakers rack were noted to be rusted and soiled and in need of replacement.</p> <p>Interview with the Assistant Dietary Manager and the Dietary Manager at the time of the tour, indicated the wheels of the baker's rack needed to be replaced and the oven doors and oven hood were soiled and in need of cleaning.</p>		<p>lift were cleaned. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service to be held on 4/16/13 by Dietary manager/designee regarding the following: 1. Cleaning of the convection oven doors and oven hood are now added to the A.M. and P.M. Cook cleaning schedule. 2. Baker's rack wheels were added to the Prep Cook weekly cleaning schedule. In-service to be held on 4/17/13 by Housekeeping manager/designee regarding the following: 1. Cleaning the mechanical lifts and weight scales located in the hallway 2. Cleaning the base coves and bathroom floor tiles 3. Completing Maintenance Request Slip as needed if they observe items in need of repair such as tile, caulk, etc. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Dietary</p>		

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			<p>manager/Designee will monitor the items on the Cook and Prep Cook cleaning schedules weekly for one month, then monthly thereafter. Audit tool attached. A summary of the audits will be presented to the Quality Assurance committee monthly by Dietary Supervisor/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Maintenance Supervisor/designee will check bathroom faucets in all resident rooms during monthly Preventative Maintenance rounds. Audit tool attached. A summary of the audits will be presented to the Quality Assurance committee monthly by Maintenance Supervisor/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>_____ Dy er Nursing &amp; Rehabilitation Center submits the following IDR for F465 and respectfully requests your consideration in lowering the scope of the severity. <b>Dyer Nursing &amp; Rehabilitation</b></p>		

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			<p><b>Center Informal Dispute Resolution F-465</b> On 4/4/2013 ISDH completed an annual survey citing the facility F465 at a "F". A scope of "F" is defined as 'No actual harm with potential for more than minimal harm that is not an immediate jeopardy. Dyer Nursing &amp; Rehabilitation Center does ensure proper sanitary conditions in the kitchen and throughout the facility. The facility respectfully requests your consideration in lowering the scope of severity for the F465 violation. <b>Introduction</b> The 2567 on page 33, 1a alleges <i>four of four convention oven doors has a yellow buildup of grease</i>. The 2567 omits the fact the alleged grease was located on the <u>outside</u> of the oven doors and at no time ever came in contact with any food products. No potential for 'more than minimal harm' could have occurred. The 2567 on page 33, 1b alleges <i>the outside edge of the oven hood had a buildup of yellow grease</i>. The 2567 omits the fact the oven hood is a separate piece of equipment and is located above the convention oven. It is impossible for food to come in contact with this piece of equipment and the alleged grease observed. No potential for 'more than minimal harm' could have occurred. The 2567 on page 33, 1c alleges <i>four of four wheel of the dessert bakers rack were noted to be rusted and soiled and</i></p>		

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			<p><i>in need of replacement.</i> The 2567 omits the fact the dessert bakers rack is a closed unit which has a door containing several racks inside. The food items are placed on individual plates and then on a large serving sheet. This serving sheet is then placed on the racks inside of the dessert rack and then the door is shut. At no time did any food items ever come in contact with the wheels <u>on the outside of the unit on the bottom of the cart.</u> No potential for 'more than minimal harm' could have occurred. The 2567 on page 34, 2a alleges <i>in room 105, the floor tile next to the entertainment center was discolored. The bathroom floor tile was dusty and dirty. An accumulation of dust and dirt was observed along the cove base in the bathroom.</i> The 2567 omits the fact neither resident in room 105 had any falls or any behaviors which placed them on the floor in contact with the alleged dust and dirt or discolored tile. No potential for 'more than minimal harm' could have occurred. The 2567 on page 34, 2b alleges <i>in room 103, the bathroom floor tile was discolored. The floor tiles at the base of the toilet was discolored with an orange substance.</i> The 2567 omits the fact neither resident had any falls or any behaviors which placed them on the floor in contact with the alleged discolored tile. No</p>	

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			<p>potential for 'more than minimal harm' could have occurred. The 2567 on page 34, 2c alleges <i>in room 102, the bathroom floor tile was discolored. An accumulation of dust and dirt was observed along the cove base in the bathroom. Lime build up was observed on the bathroom faucet. Further the faucet on the bathroom sink was loose.</i> The 2567 omits the fact neither resident had any falls or any behaviors which placed them on the floor in contact with the alleged discolored tile, dust, dirt or lime. No potential for 'more than minimal harm' could have occurred. The 2567 on page 34, 2d alleges <i>in room 101, the bathroom floor tile was discolored and the caulk around the base of the toilet was also discolored.</i> The 2567 omits the fact the resident did not have any falls or any behaviors which placed them on the floor in contact with the alleged discolored tile or caulk. No potential for 'more than minimal harm' could have occurred. The 2567 on page 35, 2e alleges <i>the East unit shower room floor was wet and water was left running in 1 of the 2 shower stalls. Two of 2 soap dispensers mounted on the wall had a heavy buildup of dried liquid soap. Adjacent to the shower stalls was a room that housed the wheel chair scale. Directly next to the scale, was an area where a bathtub had been</i></p>	

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			<p><i>removed and the floor tiles were missing. The 2567 omits the fact the shower room is locked and a key is needed to get in. No resident goes into the shower room without a staff member present. The wheel chair scale was located so the resident could be rolled directly onto the scale and not over the part of the un-tiled floor. No potential for 'more than minimal harm' could have occurred. The 2567 on page 35, 3a alleges in room 152, the bathroom floor tile was discolored. There was dirt observed around the baseboard in the bathroom and behind the toilet. The caulking around the toilet was discolored with a brown substance. The 2567 omits the fact neither resident had any falls or any behaviors which placed them on the floor in contact with the alleged discolored tile/caulk or dust. No potential for 'more than minimal harm' could have occurred. The 2567 on page 35, 3b alleges in room 188, the edge of the bottom of the shower in the bathroom was discolored and soiled and in need of cleaning. The inside of the bathroom door was scratched and marred. The 2567 omits the fact neither resident had any falls or any behaviors which placed them on the floor in contact with the bottom of the shower. Marked and scratches on a door would not contribute to any harm. No potential for 'more than minimal</i></p>	

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	<p>2. On 4/2/13 at 10:50 a.m., during the Environmental tour with the Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>The East Unit:</p> <p>a. In Room 105, the floor tile next to the Entertainment Center was discolored. The bathroom floor tile was dusty and dirty. An accumulation of dust and dirt was observed along the cove base in the bathroom. Two residents resided in this room.</p> <p>b. In Room 103, the bathroom floor tile was discolored. The floor tile at the base of the toilet was discolored with an orange substance. Two residents resided in this room.</p>		<p>harm' could have occurred. The 2567 on page 35, 3c alleges <i>the wheel chair scale and the sit to stand lift in the hallway had an accumulation of dust and dirt on the base</i>. Dust and dirt on the base of a wheel chair scale does not pose the potential for 'more than minimal harm'. <b>Conclusion</b> The facility respectfully requests that F465 be reduced in scope in severity based on the above evidence showing in no situation allegedly observed was there 'potential for more than minimal harm'.</p>		

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	<p>c. In Room 102, the bathroom floor tile was discolored. An accumulation of dust and dirt was observed along the cove base in the bathroom. Lime build up was observed on the bathroom faucet. Further, the faucet was on the bathroom sink was loose. Two residents resided in this room.</p> <p>d. In Room 101, the bathroom floor tile was discolored and the caulk around the base of the toilet was also discolored. One resident resided in this room.</p> <p>Interview with the Maintenance and Housekeeping Supervisors at this time, indicated the bathrooms were in need of cleaning and repair.</p> <p>e. The East Unit shower room floor was wet and water was left running in 1 of the 2 the shower stalls. Two of 2 soap dispensers mounted on the wall had a heavy buildup of dried liquid soap. Adjacent to the shower stalls was a room that housed the wheelchair scale. Directly next to the scale, was an area where a bathtub had been removed and the floor tiles were missing. The Maintenance Supervisor indicated residents were brought into this room to be weighed. This had the potential to affect the 69</p>			

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	<p>residents who resided on the unit.</p> <p>On 4/4/13 at 9:55 a.m., the Maintenance Supervisor indicated there were no plans to repair the floor tile floor in the East shower room and the wheelchair scale should be relocated as that room was going to be used for storage.</p> <p>3. On 4/2/13 at 10:30 a.m., during the Environmental tour with the Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>The West Unit</p> <p>a. In Room 152, the bathroom floor was discolored. There was dirt observed around the baseboard in the bathroom and behind the toilet. The caulking around the toilet was discolored with a brown substance. Two residents resided in this room.</p> <p>b. In Room 188, the edge of the bottom of the shower in the bathroom was discolored and soiled and in need of cleaning. The inside of the bathroom door was scratched and marred. Two residents resided in this room.</p> <p>Interview with the Maintenance and</p>				

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	<p>Housekeeping Supervisors at this time, indicated the bathrooms were in need of cleaning and repair.</p> <p>c. The wheelchair scale and the sit to stand lift in the hallway had an accumulation of dust and dirt on the base. Interview with the Housekeeping Supervisor at the time, indicated that she would clean the equipment.</p> <p>3.1-19(f)</p>			

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R000042	<p>410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.</p> <p>Based on observation and interview, the facility failed to ensure the results of the last survey were readily available. This had the potential to affect the 48 residents who resided in the Assisted Living facility.</p> <p>Findings include:</p> <p>On 4/4/13 at 9:00 a.m., during the Environmental tour, the survey results were not available. There was no sign posted indicating the location of the survey results.</p> <p>Interview with CNA #1 on 4/4/13 at 9:10 a.m., indicated she was unaware of the whereabouts of the survey book from the previous survey.</p> <p>Interview with the Care Coordinator on 4/4/13 at 9:20 a.m., indicated the survey book was always on the desk by the front door. She further indicated there was no sign posted to indicate the location of the book.</p>	R000042	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> No residents suffered any negative outcomes related to the survey results not being available. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. A copy of the survey results were placed in the Gathering room across from the dining area. The location of the survey is posted on the bulletin board outside of the main dining room of Sheffield Manor. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-service held on 4/18/13 by Resident Care Coordinator/designee with Sheffield Manor staff regarding the following: 1. Where the survey results are located 2. Where the location is posted <b>How</b></p>	04/26/2013			

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			<p><b>the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Monthly the Activity Coordinator/designee will ensure the results of the past surveys are available in the Gathering room across from the dining area prior to every resident council meeting. If they are not available, a copy will be made and placed in a binder and put back in the Gathering room A summary of the observations will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	

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R000120	<p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure each licensed staff member received</p>	R000120	What corrective action(s) will be accomplished for those residents found to have been	04/26/2013			

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	<p>at least eight hours of inservice per calendar year for 2 of 2 licensed staff members reviewed. (RN #1 and LPN #4)</p> <p>Findings include:</p> <p>Review of the inservice book on 4/3/13 at 2:00 p.m., indicated RN #1 and LPN #4 had not attended any inservices from 1/2012 through 3/2013.</p> <p>Interview with the Care Coordinator on 4/3/13 at 2:20 p.m., indicated she had thought the Human Resource Supervisor from the Skilled Facility was keeping track of her staff inservices. She further indicated her nursing staff only work every other weekend and had not attended any of the required inservices.</p>		<p><b>affected by the deficient practice;</b> No residents suffered any negative outcomes related to the lack of at least eight hours of inservice per calendar year for the two licensed staff members. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. The two licensed staff members were provided inservices to be completed to satisfy the inservice hour requirements. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-service held on 4/18/2013 by Resident Care Coordinator/designee regarding the following: 1. All licensed staff members are required to have at least 8 hours of inservice education per calendar year. These hours can be obtained by inservices held at the facility, outside companies, online, or from nursing magazines. If obtained outside the facility or online, a copy of the certificate of attendance should be provided to show the following information: a. Time, date and location b. Name and title of instructor c. Program content <b>How the</b></p>		

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			<p><b>corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Monthly the Resident Care Coordinator/designee will log any inservice hours attended by the licensed nursing staff members and audit the log sheets to monitor the number of hours attended so far. A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	

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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred walls, dirty toilet seats, and dirty floors. This had the potential to effect 48 of 48 residents who resided in the Assisted Living facility.</p> <p>Findings include:</p> <p>1. On 4/4/13 at 9:00 a.m., during the Environmental Tour, the following was observed:</p> <p>A. In room 220 the toilet seat was observed with a brown substance on the raised seat. There were food crumbs also noted on the floor. Interview with the Care Coordinator on 4/4/13 at 9:30 a.m., indicated the resident was assisted by staff and the toilet seat should have been cleaned.</p> <p>B. The floor between the washing machines in the laundry room on the first floor was observed with a heavy accumulation of adhered dirt and dust. There were also clothing items between the machines. Interview with</p>	R000144	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> No residents suffered any negative outcomes related to the areas found in need of cleaning or repair. The toilet seat of room 220 was cleaned and the crumbs were removed from the floor. The floor between the washing machines in the laundry room on the first floor was cleaned. The clothing item was removed. The walls in the main dining room were cleaned and repaired. The doors leading in to the servery were repaired. The walls in the lounge area were repaired. The black marks on the ceiling were removed. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-service held on 4/18/13 by</p>	04/26/2013			

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	<p>the Housekeeping Supervisor at the time, indicated there was no cleaning schedule in place to ensure the floors were cleaned.</p> <p>C. The walls in the Main Dining Room were marred, black scuffed, and chipped. The doors leading into the servery were also marred and scuffed.</p> <p>D. The walls in the Lounge area were marred and scuffed. There were black marks noted on the ceiling where each light fixture was observed.</p> <p>Interview with the Maintenance Director at the time, indicated all the above areas were in need of cleaning and/or repair.</p>		<p>Resident Care Coordinator/designee regarding the following: 1. During rounds, ensure the resident's rooms are clean. 2. If in the course of providing care and area is in need of cleaning, alert housekeeping 3. During rounds of common areas, observe for any marred areas in need of painting and or black or scuff marks. Alert housekeeping and/or maintenance for the area in need of repair. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Monthly Maintenance Director/designee will complete rounds of the common areas to determine if any are in need of repair. A summary of any repairs required/performed will be presented to the Quality Assurance committee monthly by Administrator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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R000154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to provide a sanitary environment related to soiled oven doors, soiled oven hood and soiled wheels on a baker's rack in 1 of 1 kitchen. This had the potential to effect 48 of 48 residents who consumed food prepared in the facility's kitchen. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. The Kitchen Sanitation Tour was completed on 4/2/13 at 10:15 a.m., with the Assistant Dietary Manager and the Dietary Manager. The following was observed:</p> <p>a. Four of four convention oven doors had a yellow buildup of grease. The doors were in need of cleaning.</p> <p>b. The outside edge of the oven hood had a buildup of yellow grease and was in need of cleaning.</p> <p>c. Four of four wheels of the dessert bakers rack were noted to be rusted and soiled and in need of</p>	R000154	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents suffered any negative outcomes related to the areas found in need of cleaning.</p> <p>Convection oven doors and oven hood were cleaned and tasks were added to A.M. and P.M. Cook cleaning schedule.</p> <p>Baker's rack wheels were changed. Baker's rack wheels were added to Prep Cook weekly cleaning schedule.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to</b></p>	04/26/2013			

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	<p>replacement.</p> <p>Interview with the Assistant Dietary Manager and the Dietary Manager at the time of the tour, indicated the wheels of the baker's rack needed to be replaced and the oven doors and oven hood were soiled and in need of cleaning.</p>		<p><b>ensure that the deficient practice does not recur;</b></p> <p>In-service to be held on 4/16/13 by Dietary manager/designee regarding the following:</p> <ol style="list-style-type: none"> <li>Cleaning of the convection oven doors and oven hood are now added to the A.M. and P.M. Cook cleaning schedule.</li> <li>Baker's rack wheels were added to the Prep Cook weekly cleaning schedule.</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Dietary manager/Designee will monitor the items on the Cook and Prep Cook cleaning schedules weekly for one month, then monthly thereafter. Audit tool attached.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by Dietary Supervisor/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an assessment was completed for a resident who was observed to self administer medications for 1 of 3 residents reviewed for self administration of medication in the sample of 7. (Resident #3)</p> <p>Findings include:</p> <p>On 4/3/13 at 8:20 a.m., RN #1 was observed preparing medication for Resident #3. At that time, the RN indicated the resident receives Advair (an inhaler) 250/50 one inhalation. The RN further indicated the Advair diskus was in the resident's room. After pouring all of the resident's medications, the RN then walked into</p>	R000216	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for the R3 are as follows: The medication was removed from the bedside. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Resident apartments were inspected to ensure no other medications had been left at the bedside unless the resident was deemed able to administer their own medications. No other inappropriate medications were noted at the bedside. <b>What</b></p>	04/26/2013			

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	<p>the resident's room. The Advair diskus was located on the resident's coffee table. The nurse administered the resident's insulin, oral medications and gave her another inhaler to use. The RN watched the resident inhale the other inhaler and then instructed the resident to wait five minutes before using the Advair diskus and then to rinse out her mouth after she used it. The RN then walked out of the resident's room and did not observe the resident use the Advair diskus.</p> <p>Interview with RN #1 at that time, indicated the resident was able to self administer her inhalers. She further indicated the resident can have the inhalers in her room.</p> <p>The record for Resident #3 was reviewed on 4/3/13 at 9:30 a.m. Review of Physician Orders, indicated there was no order for the resident to self administer her own medications.</p> <p>Review of the Functional Assessment updated on 1/23/13, indicated medications were to be administered as ordered by the Physician.</p> <p>Review of the current Service Plan updated 1/23/13, indicated there was no assessment the resident could self</p>		<p><b>measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-service held on 4/18/13 by Resident Care Coordinator/designee regarding the following: 1. Medications may not be left at the bedside unless the resident has been evaluate to self administer their own medications. 2. If the resident wishes to administer their own medications, an assessment must be completed to determine if the resident is capable of performing this task 3. A physician order will be obtained for which medication(s) the resident may administer . <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> The Resident Care Coordinator/designee will observe the medication pass of 5 residents weekly to ensure medications are not left at the bedside unless resident is able to administer their own medications. A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at</p>		

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	<p>administer her own medications.</p> <p>Interview with the Care Coordinator on 4/3/13 at 2:20 p.m., indicated the resident was able to self administer her own insulin via the Insulin Pen after the nurse or QMA dialed in the units. She further indicated the resident was not assessed to self administer her own inhalers. The Care Coordinator indicated the Advair diskus should not have been left in the resident's room and the RN should have stayed with the resident until all the medications were administered including the inhalers.</p>		<p>the QA meeting. Monitoring will be on going.</p>		

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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident was free from medication errors related to the administration of oral medications for 2 of 5 residents reviewed during medication pass. (Residents #1 and #3)</p> <p>Findings include:</p> <p>1. On 4/3/13 at 8:20 a.m., RN #1 was observed preparing medication for Resident #3. At that time, RN #1 poured 1 capsule of Lovaza (a medication used to lower triglycerides) into the medication cup. Review of the label of the bottle indicated Lovaza 1 gram give 2 capsules twice a day. After RN #1 had poured all of the resident's medications, and was ready to administer the medication, she was asked to review the label and Medication Administration Record (MAR) again regarding the Lovaza.</p>	R000241	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective actions for R3 is as follows: R3 medication administration record and the label on the medication box reviewed.</p> <p>The corrective action for R1 is as follows: R1 medication administration record and the label on the medication box reviewed and corrected.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into</b></p>	04/26/2013	

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	<p>Interview with RN #1 at the time, indicated she should have poured two capsules of the Lovaza instead of one.</p> <p>The record for Resident #3 was reviewed on 4/2/13 at 9:30 a.m. Review of the current Physician Orders dated 9/18/12, indicated Lovaza 1 gram capsule give 2 capsules twice a day.</p> <p>2. On 4/3/13 at 8:30 a.m., RN #1 was observed preparing medication for Resident #1. At that time, RN #1 poured two capsules of Coq10 (a co-enzyme vitamin) 200 milligrams (mg) into the medication cup. The medication was an over the counter medication.</p> <p>The record for Resident #1 was reviewed on 4/3/13 at 10:00 a.m. Review of Physician Orders dated 3/5/13, indicated Coq10 200 mg give one capsule daily.</p> <p>Review of the 3/13 Medication Administration Record (MAR), indicated Coq10 200 mg give 2 capsules daily.</p> <p>Interview with the Care Coordinator on 4/3/13 at 10:45 a.m., indicated she had called the pharmacy and they</p>		<p><b>place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/18/13 by Resident Care Coordinator/designee regarding the following:</p> <p>1. During medication pass, compare the instructions in the physician order on the medication administration record with the instructions on the medication box/bottle. If there is a discrepancy, check the physician order in the chart. Place a direction change sticker on the medication box/bottle if needed or write a new entry on the medication administration record, which ever is in error.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Weekly the Resident Care Coordinator/designee will observe the medication pass of 5 residents weekly to ensure the proper dosage is given per physician order. If an incorrect dose is observed during the nurse preparing the medications, the nurse will be alerted at that time to prevent a medication error. Re-education will be done immediately with the nurse</p>				

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	indicated they had switched the dosage from 1 to 2. She further indicated the correct dose should be to give one capsule and not two.		regarding proper review of the order vs. the label.  A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.		

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R000306	<p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:</p> <ol style="list-style-type: none"> <li>(1) The name of the resident.</li> <li>(2) The name and strength of the drug.</li> <li>(3) The prescription number.</li> <li>(4) The reason for disposal.</li> <li>(5) The amount disposed of.</li> <li>(6) The method of disposition.</li> <li>(7) The date of the disposal.</li> <li>(8) The signature of the person conducting the disposal of the drug.</li> <li>(9) The signature of a witness, if any, to the disposal of the drug.</li> </ol> <p>Based on observation, record review, and interview, the facility failed to ensure all medications were properly disposed of when dropped for 2 of 5 residents observed during medication pass. (Resident's #1 and #3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 4/3/13 at 8:20 a.m., RN #1 was observed preparing medication for Resident #3. At that time, she removed a Spiriva capsule and took it into the resident's room with her. She then opened the capsule and it dropped on the floor in the resident's room by the sink. She then picked up the capsule and placed it into the</li> </ol>	R000306	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>R3 and R1 suffered no negative outcomes related to having the medications thrown away in the bedside trash and the side of the medication cart.</p> <p>R3 trash bag containing the medication was removed from the apartment and properly disposed of.. The trash bag was removed from the side of the nursing medication cart and properly disposed of.</p> <p><b>How the facility will identify other residents having the</b></p>	04/26/2013			

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	<p>garbage can under the resident's sink. She then left the room and got another capsule from the Medication cart. This time, she attempted to open the capsule and it had fallen into the resident's sink. She picked up the capsule and again threw it away in the garbage can under the resident's sink.</p> <p>Interview with RN #1 on 4/3/13 at 9:00 a.m., indicated medications were to disposed of in the sharps container located in the medication room or on the side of the medication cart. She further indicated she should not have thrown the Spiriva capsules into the resident's garbage can.</p> <p>2. On 4/3/13 at 8:30 a.m., RN #1 was observed preparing medication for Resident #1. At that time, she poured Potassium Chloride 20 meq into a medication cup. She further indicated the resident likes the Potassium split into two pieces, because it was so large. The RN then placed the pill into the splitter, she pressed down on the tablet and it broke into four pieces. She then indicated she would have to split another pill. She took three of the four pieces and threw them away in the garbage can on the side of the medication cart. She placed the</p>		<p><b>potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/18/13 by Resident Care Coordinator/designee regarding the following:</p> <ol style="list-style-type: none"> <li>How to properly dispose of the un-used medications in the sharps container in the rooms or on the side of the medication cart.</li> <li>Medications can never be thrown away in the bedside trash, bathroom trash or any trash container in the apartment.</li> <li>Medications can not be thrown away in the regular trash bag located on the medication cart or a trash can in the nurse station of common area.</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p>				

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	<p>fourth piece into the medication drawer. The RN then removed another Potassium pill, placed gloves on her hands and split the pill. She then administered the resident's medications.</p> <p>Review of the 1/1/05 Medication Destruction Policy provided by the Care Coordinator, indicated Drug destruction should be carried out in accordance with the polices of the facility and recommendation of the local environmental agencies. In most cases the biohazard box can be used for solid medications. Destruction occurs in the presence of two licensed nurses or one licensed nurse and a pharmacist or a licensed nurse and a QMA in Indiana."</p> <p>Interview with RN #1 on 4/3/13 at 9:00 a.m., indicated medications were to disposed of in the sharps container located in the medication room or on the side of the medication cart. She further indicated she should not have thrown the Potassium pieces into the garbage can on her medication cart.</p>		<p>The Resident Care Coordinator/designee will observe the medication pass of 5 residents weekly to ensure any un-used medications are disposed of in the proper container. The nurse will be corrected immediately if they are observed attempting to thrown a medication away in an inappropriate area.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure each resident's clinical record was complete and accurately documented related to a Physician's Order for a foley catheter and follow up documentation after a significant change in status for 2 of 7 residents reviewed for clinical records in the sample of 7. (Residents #4 &amp; #5)</p> <p>Findings include:</p> <p>1. The record for Resident #5 was reviewed on 4/3/13 at 10:50 a.m. Review of Nursing Progress Notes dated 3/4/13 at 10:00 a.m., indicated the CNA had come to get the nurse to assess the resident's right foot. The resident's right foot was swollen and discolored. The resident did not know how her ankle became swollen and discolored. The resident's Physician was notified and new orders were obtained. The next documented entry</p>	R000349	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective action for R5 is as follows: R5 condition to the foot has resolved.</p> <p>The corrective action for R4 is as follows: An order was obtained for the foley.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. The orders for all residents with foleys were reviewed to ensure appropriate orders were in place.</p>	04/26/2013			

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	<p>in the Nursing Progress Notes was on 3/5/13, indicating the resident had tripped over her oxygen tubing and fell to the ground. There was no documentation regarding the resident's right foot.</p> <p>Further review of Nursing Progress Notes indicated 3/5/13 was the last documented entry. There were no other Nursing Progress Notes. There was no further documentation regarding the resident's right foot or the fall.</p> <p>Interview with the Care Coordinator on 4/3/13 at 1:00 p.m., indicated every time a resident has a change in condition, nurses should document for 72 hours post the incident. She further indicated there was no further follow up documentation regarding the right foot or the fall.</p> <p>2. The record for Resident #4 was reviewed on 4/3/13 at 11:30 a.m. Review of the Functional Assessment dated 2/7/13, indicated the resident had an indwelling foley catheter.</p> <p>Review of Physician Orders dated 2/7/13 and on the current 2/13 recap, indicated there was no order for the foley catheter.</p>		<p>All residents were reviewed to determine if a change in condition was currently going on and included on the 24 hour report.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-service held on 4/18/13 by Resident Care Coordinator/designee regarding the following:</p> <ol style="list-style-type: none"> <li>If a resident has a change in condition, follow up documentation is required for 72 hours. The change of condition should also be entered on the 24 hour report to alert staff who needs follow up charting</li> <li>If a resident has a foley, a physician order should be obtained. The order should include the size of the foley and site care</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>The Resident Care Coordinator/designee will audit the nursing charting twice weekly to ensure required follow up charting is present.</p>		

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	Interview with the Care Coordinator on 4/3/13 at 12:00 p.m., indicated there was no written Physician's Order for the foley catheter.		The Resident Care Coordinator/designee will review all residents twice weekly to determine if there are any who have had a foley inserted and ensure all proper orders are in place. If the orders are not observed, the physician will be contacted as soon as possible and the orders obtained.  A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.		

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R000407	<p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, record review and interview, the facility failed to ensure infection control was maintained related to glove usage while injecting Insulin for 1 of 1 resident's observed for Insulin injections. (Resident #3)</p> <p>Findings include:</p> <p>On 4/3/13 at 8:20 a.m., RN #1 was observed preparing medications for Resident #3. At that time, she indicated the resident was to receive 25 units of Novolog Insulin based on her blood sugar results. The RN then opened the resident's refrigerator and pulled out an Insulin Pen. She then dialed the pen to 25 and removed the cap. The RN then wiped the resident's arm with an alcohol wipe and administered the injection into</p>	R000407	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>R3 suffered no ill effects from the nursing not wearing gloves during an insulin pen injection.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p>	04/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/04/2013
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	<p>her left arm. The RN did not wear any gloves to either one of her hands. The RN then washed her hands with soap and water.</p> <p>Interview with RN #1 on 4/3/13 at 9:20 a.m., indicated she was supposed to wear gloves while administering any injections to the resident.</p> <p>Review of the 1/1/05 Standard Precautions Policy provided by the Care Coordinator indicated "When administering medications or treatments, Standard Precautions will be used as appropriate. Gloves will be worn when contact with the resident is possible, i.e. injections...."</p>		<p>In-service held on 4/18/13 by Resident Care Coordinator/designee regarding the following:</p> <ol style="list-style-type: none"> <li>Gloves must be worn when administering any injection to a resident.</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>The Resident Care Coordinator/designee will observe the medication pass of 5 residents weekly, including those that receive an injection, to ensure gloves are worn during the administration. If the nurse is observed attempting to give the injection without gloves, the nurse will be corrected immediately prior to giving the injection.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		