

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2014
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NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 14, 15, 16, 17, and 18, 2014.</p> <p>Facility number: 000087 Provider number: 155171 AIM number: 100289890</p> <p>Survey Team: Dorothy Plummer, RN-TC Marsha Smith, RN Karyn Homan, RN Patsy Allen, SW</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 8 Medicaid: 68 Other: 14 Total: 90</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 24, 2014; by Kimberly Perigo, RN.</p>	F000000	<p>8/5/14 To Whom It May Concern: On July 14, 2014 a Health Survey was conducted at Franklin Meadows Skilled Nursing Facility. This letter is attached to the plan of correction, which does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. We are respectfully requesting that the attached plan of correction be considered the letter of credible allegation and requesting a desk review, in lieu of a Post Survey review. Thank you very much for your time and consideration. Sincerely, Michael Kalmas Executive Director Franklin Meadows</p>	
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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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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the dignity and comfort of residents who were severely cognitively impaired and who need extensive assistance to move from one location to another, for a period of approximately 1 hour prior to the noon meal. (Residents #53, #65, #18, #41, and #49)</p> <p>Findings include:</p> <p>During a random observation of the noon meal on 7/17/14 at 11:25 a.m., in the main dining room (Meadows Cafe), 5 residents were observed to be sitting at the seats assigned to them for the noon meal. At that time, the Activities Director indicated she had brought these residents into the dining room on that day at 10:30 a.m., to participate in an activity. She indicated the activity had ended</p>	F000241	<p>PLAN OF CORRECTION</p> <p>Franklin Meadows The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a <u>Desk Certification Review</u> on or after August 7, 2014.</p> <p><u>F-241</u></p> <p>The facility strives to ensure that the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> · Resident #53, #65, #18, #41, 	08/07/2014	

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	<p>about 11:25 a.m., and at that time, the 5 residents were moved to their assigned seats for the noon meal. These 5 residents were not observed conversing with other residents or staff and were not involved in an independent or group activity while waiting to be served the noon meal.</p> <p>A poster on the wall in the Admissions Office indicated the noon meal in the Meadows Cafe dining room was scheduled to be served at 12:15 p.m.</p> <p>Resident #53 was sitting at her assigned seat at 11:25 a.m. Her annual Minimum Data Set (MDS) assessment dated 5/7/14, indicated she was severely cognitively impaired and was totally dependent on staff for locomotion from her room to the dining room. A drink was not given to the resident until 12:26 p.m., and food was not placed in front of the resident until 12:37 p.m.</p> <p>Resident #65 was seated at her assigned seat at 11:25 a.m. A significant change MDS dated 5/23/14, indicated she was severely cognitively impaired and totally dependent on staff for locomotion from her room to the dining room. A drink was not given to the resident until 12:26 p.m., and food was not placed in front of the resident until 12:30 p.m.</p>		<p>and #49 continue provided with an independent or group activity while waiting to be served. Staff understanding and practice on enhancing each resident's well being and respect for full recognition of his/her individuality by providing independent or group activities while waiting to be served at meals. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents with severe cognitive impairment have the potential to be affected. Staff have been re-educated on enhancing each resident's well being and respect for full recognition of his/her individuality by the ADNS on August 7, 2014. Activity staff has adjusted the activity calendar to ensure that an independent or group activity will occur while waiting to be served at noon meals. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Staff re-educated on enhancing each residents well being and respect for full recognition of his/her individuality by providing independent or group activities while waiting to be served at meals. In-services held by ADNS/designee and completed by August 7, 2014. · Residents will not be in dining room for extended period of time</p>		

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	<p>Resident #18 was seated at her assigned seat at 11:25 a.m. A quarterly MDS dated 6/30/14, indicated she was severely cognitively impaired and needed the extensive assistance of staff for locomotion from her room to the dining room. A drink was not given to the resident until 12:22 p.m., and food was not placed in front of the resident until 12:24 p.m.</p> <p>Resident #41 was seated at his assigned seat at 11:25 a.m. A quarterly MDS dated 6/17/14, indicated he was severely cognitively impaired and was totally dependent on staff for locomotion from his room to the dining room. Food and a drink was not placed in front of the resident until 12:27 p.m.</p> <p>Resident #49 was seated at her assigned seat at 11:25 a.m. A quarterly MDS dated 6/17/14, indicated she was severely cognitively impaired and needed extensive assistance of 1 staff person for locomotion from her room to the dining room. A drink was not given to the resident until 12:24 p.m., and food was placed in front of the resident at 12:29 p.m.</p> <p>A review resident council minutes, dated 6/27/15 at 2:45 p.m., indicated,</p>		<p>prior to meal time. Residents that are waiting for an extended period of time in the dining room prior to a meal will be offered an independent or group activity. ED/Designee to monitor prior to meals to ensure that residents are provided an independent or group activity if waiting for an extended period of time. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>An Activity CQI tool will be utilized to ensure residents who remained in the dining room for an extended period of time following an activity prior to a meal have independent or group activity prior to varying meals for 10 times per week x4 weeks, then 5 times per week x3, and then 5 times per month x 4. Threshold of 95% will be maintained or an action plan will be developed. Data will be submitted to the CQI Committee for review and follow up. If threshold is not met an action plan will be developed.</p> <p>Compliance date: August 7, 2014</p>		

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F000272 SS=D	<p>"Residents concerned with not getting drinks served at meals in main dining room."</p> <p>Further information was requested from the Executive Director on 7/17/14 at 2:15 p.m., regarding why Residents #53, #65, #18, #41, and #49, who were severely cognitively impaired in their ability to make decisions, and who needed extensive or total assist from staff for movement from one location to another, had to wait at their assigned seats for approximately 1 hour before food or drink was given to them.</p> <p>On that date at 4:00 p.m., the Executive Director indicated, starting 7/18/14, residents who remained in the dining room for a period of time prior to a meal being served, would be given drinks and independent activities to do.</p> <p>3.1-3(t)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the</p>						

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	<p>resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure comprehensive assessments were accurately completed for a resident having loose fitting dentures on the Minimum Data Set (MDS) assessment for 1 of 2 residents meeting the criteria for dental review. (Resident # 7)</p> <p>Findings include:</p>	F000272	<p><u>F-272</u></p> <p>The facility strives to ensure that the facility conducts initial and periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <p>Resident #7 still resides in the facility. Resident's minimum data set</p>	08/07/2014

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	<p>The clinical record of Resident #7 was reviewed on 7/17/14 at 12:30 p.m. Diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), Alzheimer's disease, hypertension (high blood pressure), and schizophrenia (a mental health condition which causes abnormal thinking).</p> <p>A quarterly MDS, completed 1/14/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 6, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. Section L "Oral/Dental Status" of the quarterly assessment lacked documentation of assessment.</p> <p>A quarterly MDS, completed 4/14/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 6, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. Section L "Oral/Dental Status" of the quarterly assessment lacked documentation of assessment.</p> <p>A annual MDS, completed 7/8/14,</p>		<p>has been updated to accurately reflect section L "Oral/Dental Status".</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents needing dentures have the potential to be affected. List of all residents with dentures has been developed and all resident's minimum data sets reflect the need for Oral/Dental Status on August 7, 2014. · What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. · All Residents identified to be needing dentures have had the minimum data set section "Oral Status" updated to accurately reflect current status on August 7, 2014. · New admissions are reviewed by IDT to ensure that all residents with dentures are identified and MDS Coordinator/designee will then mark section "oral status" on the minimum data set. · All resident's needing dentures have been identified and a 100% audit of all residents needing dentures has been completed to ensure that section "oral status" is coded on their minimum data set. · Staff educated on the 				

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	<p>assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 5, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. In Section L "Oral/Dental Status" of the annual assessment, Resident #7 was assessed as "None of the Above." Number A in Section L indicated "... Broken or loosely fitting full or partial denture..."</p> <p>During a Stage 1 family interview on 7/15/14 at 12:30 p.m., a family member expressed concern that Resident #7 had difficulty chewing food due to a loose fitting upper denture. The denture was described as loose and frequently falling down while Resident #7 was eating. The family member indicated the concern with the loose fitting denture had been mentioned to the staff "some time ago," but the denture remained loose fitting.</p> <p>During an interview with the Social Services Director (SSD) on 7/16/14 at 4:15 p.m., the SSD indicated Resident #7 was seen by the facility dentist on 12/18/13. The SSD provided a copy of "PrevMed Communication Sheet" dated 12/18/13. Resident #7 was listed on the communication sheet with documentation</p>		<p>identification of dentures upon admission assessment on <i>August 7, 2014</i>.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A Dental Service CQI tool will be utilized to determine if a new resident has dentures upon admission for every new admission for x4 weeks, then all admissions will be reviewed weekly x3, and then all admissions will be reviewed monthly x 4. Threshold of 95% will be maintained or an action plan will be developed. Data will be submitted to the CQI Committee for review and follow up. If threshold is not met an action plan will be developed. <p>Compliance date: <i>August 7, 2014</i></p>				

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	<p>indicating the resident needed a reline of the denture. The PrevMed Dental Progress Note, dated 12/18/13, indicated Resident #7 was advised to use adhesive to the denture until assessment was completed for a reline.</p> <p>A nursing progress note, dated 1/25/14 at 10:44 p.m., indicated Resident #7 had denture "drop down from palate" during an episode of anxiety.</p> <p>During review of an "Observation Report" for Resident #7, dated 2/28/14 at 8:54 p.m., under "Oral Status" Resident #7 was assessed as having broken or loosely fitting full or partial denture.</p> <p>During an interview with the SSD on 7/16/14 at 4:15 p.m., the SSD provided a copy of "Dentist Daily Billing Report" for service date 2/26/14, indicating Resident #7 was delivered a denture which had been relined.</p> <p>During a review of the care plan and interventions for Resident #7, Resident #7 had a problem category of self care deficit with an intervention to provide oral care twice a day. The careplan lacked documentation indicating Resident #7 had an upper denture.</p> <p>During an interview with CNA #2 on</p>			

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F000282 SS=D	<p>7/17/14 at 12:10 p.m., CNA #2 indicated Resident #7 preferred to leave upper denture out as the denture was very loose and would not stay in place, especially at mealtimes. CNA #2 indicated adhesive was used to try to help secure the denture, but the denture would still fall down when the resident was trying to eat. CNA #2 indicated Resident #7 had seen the dentist regarding the loose fitting plate, but the denture remained loose.</p> <p>During an interview with the Director of Nursing on 7/17/14 at 4:22 p.m., the DoN indicated the "Resident Profile" was utilized as an assignment sheet for the certified nursing assistants (CNA). A review of the Resident Profile for Resident #7 indicated Resident #7 was to be provided with oral care twice a day, but lacked documentation indicating Resident #7 had an upper denture. The DoN indicated the MDS coordinator was on vacation, and was not available to answer questions related to the MDS assessments.</p> <p>3.1-31(c)(9)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the</p>			

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	<p>facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident having a loose fitting denture was re-assessed by the dentist as indicated by current physician's orders for 1 of 2 residents meeting the criteria for dental review. (Resident # 7)</p> <p>Findings include:</p> <p>The clinical record of Resident #7 was reviewed on 7/17/14 at 12:30 p.m. Diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), Alzheimer's disease, hypertension (high blood pressure), and schizophrenia (a mental health condition which causes abnormal thinking).</p> <p>A quarterly MDS, completed 1/14/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 6, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. Section L "Oral/Dental Status" of the quarterly assessment lacked documentation of assessment.</p>	F000282	<p>F-282</p> <p>The facility strives to ensure that recommendations initiated by qualified persons are followed for all Residents.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> Resident #7 still resides in the facility & the care-plan has been accurately updated. Resident's POA has been contacted regarding loose fitting dentures. Resident's POA has determined that no further follow up is needed and does not want resident #7's dentures adjusted any longer due to resident #7 having no chewing/swallowing issues, no weight issues and not wanting to wear dentures. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents needing dentures have the potential to be affected. DNS/designee conducted an audit of residents with dentures in the facility and the physician's order to ensure residents are receiving denture care per physician order on August 7, 2014. DNS/designee have interviewed 	08/07/2014

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	<p>A quarterly MDS, completed 4/14/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 6, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. Section L "Oral/Dental Status" of the quarterly assessment lacked documentation of assessment.</p> <p>A annual MDS, completed 7/8/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 5, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. In Section L "Oral/Dental Status" of the annual assessment, Resident #7 was assessed as "None of the Above." Number A in Section L indicated "... Broken or loosely fitting full or partial denture...."</p> <p>During a Stage 1 family interview on 7/15/14 at 12:30 p.m., a family member expressed concern that Resident #7 had difficulty chewing food due to a loose fitting upper denture. The denture was described as loose and frequently falling down while Resident #7 was eating. The</p>		<p>and assessed all residents with dentures. Any identified as loose fitting will have dentist notified on <i>August 7, 2014</i>.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ADNS/designee will in-service the nursing staff on denture care and ensuring that any loose fitting dentures are notified to supervisor upon discovery on <i>August 7, 2014</i>. DNS/Designee to assess all new residents & residents with weight loss to ensure denture needs are met and care-plan is accurately developed. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A CQI tool will be utilized to determine if a resident's dentures are fitting properly 10 per week x4 weeks, then monthly x 3 months and then quarterly x 2. Threshold of 95% will be maintained or an action plan will be developed. Data will be submitted to the CQI Committee for review and follow up. If threshold is not met an action plan will be developed. <p>Compliance date: <i>August 7, 2014</i></p>				

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	<p>family member indicated the concern with the loose fitting denture had been mentioned to the staff "some time ago," but the denture remained loose fitting.</p> <p>During an interview with the Social Services Director (SSD) on 7/16/14 at 4:15 p.m., the SSD indicated Resident #7 was seen by the facility dentist on 12/18/13. The SSD provided a copy of "PrevMed Communication Sheet" dated 12/18/13. Resident #7 was listed on the communication sheet with documentation indicating the resident needed a relined of the denture. The PrevMed Dental Progress Note, dated 12/18/13, indicated Resident #7 was advised to use adhesive to the denture until assessment was completed for a relined.</p> <p>A nursing progress note, dated 1/25/14 at 10:44 p.m., indicated Resident #7 had denture "drop down from palate" during an episode of anxiety.</p> <p>During an interview with the SSD on 7/16/14 at 4:15 p.m., the SSD provided a copy of "Dentist Daily Billing Report" for service date 2/26/14 indicating Resident #7 was delivered a denture which had been relined. The SSD indicated the resident had not been seen by the dentist since 2/26/14.</p>						

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	<p>During review of an "Observation Report" for Resident #7, dated 2/28/14 at 8:54 p.m., under "Oral Status" Resident #7 was assessed as having broken or loosely fitting full or partial denture.</p> <p>During a review of the care plan and interventions for Resident #7, Resident #7 had a problem category of self care deficit with an intervention to provide oral care twice a day. The careplan lacked documentation indicating Resident #7 had an upper denture.</p> <p>During a review of the recapitulation of physician's orders for Resident #7, dated July 2014, Resident #7 was prescribed a mechanical soft diet. Resident #7 had a physician's order to see the dentist as needed.</p> <p>During an observation of Resident #7 on 7/17/14 at 12:00 p.m., Resident #7 was observed eating lunch without a denture in place.</p> <p>During an interview with the Memory Care Facilitator on 4/17/14, at 12:10 p.m., the Memory Care Facilitator indicated Resident #7 should have denture in place at mealtimes. Resident #7 was asked if she wanted to put in her denture and she indicated she did. Resident #7 was assisted to her room by</p>			

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	<p>CNA #2.</p> <p>During an interview with CNA #2 on 7/17/14 at 12:10 p.m., CNA #2 indicated Resident #7 preferred to leave upper denture out as the denture was very loose and would not stay in place, especially at mealtimes. CNA #2 indicated adhesive was used to try to help secure the denture, but the denture would still fall down when the resident was trying to eat. CNA #2 rinsed the denture plate, applied an adhesive to the plate, and handed the denture in a container to Resident #7. When asked to place the denture in her mouth Resident #7 stated, "They are too loose and keep falling out. I would rather eat with what I have." (Resident #7 pointed to her natural teeth on her bottom gum.) CNA #2 indicated Resident #7 had seen the dentist regarding the loose fitting plate, but the denture remained too loose.</p> <p>During an interview with the Director of Nursing on 7/17/14 at 4:22 p.m., the DoN indicated the "Resident Profile" was utilized as an assignment sheet for the certified nursing assistants (CNA). A review of the Resident Profile for Resident #7 indicated Resident #7 was to be provided with oral care twice a day, but lacked documentation indicating Resident #7 had an upper denture.</p>						

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F000323 SS=E	<p>3.1-35(g)(2)</p> <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, interview, and record review, the facility failed to ensure that water temperatures were kept at a safe and comfortable level for 4 of 8 rooms reviewed for water temperatures in that the water temperature was above 120 degrees Fahrenheit (unit of measurement of temperature).</p> <p>Findings include:</p> <p>During an observation dated 7/14/14 at 11:00 a.m., unit C room 138's water from the bathroom faucet was too hot to hold fingers under.</p> <p>On 7/14/14 at 11:50 a.m., Resident #131 indicated, "the water in the bathroom is super hot. Do not let the water run to long."</p> <p>During an observation dated 7/14/14 from 11:30 a.m. to 12:10 p.m., the maintenance director used a thermometer</p>	F000323	<p>F-323</p> <p>The facility strives to conduct initial and periodic comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity. What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> · Water temps will be taken and logged to ensure temperatures are maintained. · Water temps are maintained and appropriate. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected. 	08/07/2014			

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	<p>to test a sampled number of bathroom water temperatures; Unit C room 138, 122 degrees Fahrenheit Unit C room 142, 123 degrees Fahrenheit Unit A room 104, 121 degrees Fahrenheit Unit A room 118, 128 degrees Fahrenheit</p> <p>On 7/14/14 at 12:05 p.m., the Executive Director indicated, the facility would turn down the water temperature and inform the nursing staff to not use the water until it reach an appropriate temperature.</p> <p>On 7/14/14 at 12:30 p.m., the Executive Director provided the Daily Water Temperature logs from January 2014 to July 2014. He indicated, the maintenance supervisor checks the water temperature daily when he is in the building and records it on the Daily Water Temperature log.</p> <p>Review of the Daily Water Temperature log, temperatures were not recorded on these dates; January 4, 2014 January 5, 2014 January 11, 2014 January 12, 2014 January 18, 2014 January 19, 2014 January 25, 2014 January 26, 2014 February 8, 2014</p>		<ul style="list-style-type: none"> · Water temps monitored throughout facility by ED to ensure water remained below 120. · Facility will monitor water temperatures and log water temperatures daily to ensure appropriate temperatures are maintained. · On 8/1/2014 Maintenance Supervisor was re-educated on water temperatures and water temperature monitoring, by Executive Director. · On 7/15/2014 Department managers educated on water temperatures and water temperature monitoring for weekend monitoring by Executive Director. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · Maintenance Supervisor was re-educated on water temperatures and tracking on water temperature log on 8/1/2014 by Executive Director. · Department managers educated on water temperatures and tracking them on a water temperature log for weekends on 7/15/2014 by Executive Director. · Facility will monitor water temperatures in resident areas and log water temperatures to ensure appropriate temperatures are maintained, daily. · If concerns are noted, Maintenance Supervisor/Executive Director/Designee will be notified immediately for corrective action. 	

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	February 9, 2014 February 15, 2014 February 16, 2014 February 22, 2014 February 23, 2014 March 8, 2014 March 9, 2014 March 15, 2014 March 16, 2014 March 22, 2014 March 23, 2014 March 29, 2014 March 30, 2014 April 5, 2014 April 6, 2014 April 12, 2014 April 13, 2014 April 19, 2014 April 20, 2014 April 26, 2014 April 27, 2014 May 3, 2014 May 4, 2014 May 10, 2014 May 11, 2014 May 17, 2014 May 18, 2014 May 24, 2014 May 25, 2014 May 31, 2014 June 1, 2014 June 7, 2014 June 8, 2014 June 14, 2014		<ul style="list-style-type: none"> · Executive Director will review temperature log to ensure completed timely and appropriately. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · Executive Director/Maintenance Supervisor/Designee will be auditing the water temperatures in resident care areas daily and documented the water temperatures on the water temperature log. · The Safety Committee will review the audits and action plans will be developed, as needed, to ensure that no further issues arise from water temperatures being outside of guidelines. · Audits of the temperature log will be completed by Executive Director/Designee daily x 4weeks, then monthly ongoing. Audit results will be documented on the water temperature log. · Threshold of 100% will be maintained or an action plan will be developed. <p>Compliance date: August 7, 2014</p>				

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	<p>June 15, 2014 June 21, 2014 June 22, 2014 June 28, 2014 June 29, 2014 July 4, 2014 July 5, 2014 July 6, 2014 July 11, 2014 July 12, 2014 July 13, 2014</p> <p>The majority of the missing dates were on the weekends and other missing dates were on holidays. The documented temperatures were with in normal limits.</p> <p>The Daily Water Temperature log indicated, "Water temperatures should be taken and recorded daily. Randomly select the rooms and /or areas where water temperatures are to be read.... Temperatures between 100-120 should be maintained in resident care areas."</p> <p>On 7/15/14 at 9:15 a.m., the Executive Director indicated he would inservice his managers on how to take the water temperatures, so they could take them on the weekends.</p> <p>On 7/15/14 at 4:35 p.m., the Executive director indicated the facility does not have a policy regarding water</p>			

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F000329 SS=D	<p>temperatures. They follow the regulation and they check water temperatures daily to ensure the water temperatures are appropriate.</p> <p>3.1-2-45(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure monitoring for tardive dyskinesia, (abnormal involuntary movements common with the</p>	F000329	<p><u>F-329</u></p> <p>The facility strives to ensure each resident's drug regimen is free from</p>	08/07/2014	

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	<p>use of antipsychotic medications,) was in place for 2 of 5 residents reviewed for unnecessary medications. (Resident # 8 and Resident #115)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #8 was reviewed on 7/17/14 at 3:15 p.m. Diagnoses included, but were not limited to, senile dementia with delusions, diabetes mellitus, hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD). Resident #8 was re-admitted to the facility on 1/14/14.</p> <p>A review of the recapitulation of physician's orders for Resident #8, dated July 2014, indicated Resident #8 was receiving Seroquel, (an antipsychotic medication used to treat dementia related psychosis in the elderly), 25 mg (milligrams) in the morning and 75 mg at bedtime. The start date for the Seroquel was 1/14/14.</p> <p>Resident #8 had a care plan in place with a problem start date of 6/10/14, indicating Resident #8 was at risk for adverse side effects related to the use of psychotropic medication. Interventions included, but were not limited to, Abnormal Involuntary Movement Scale</p>		<p>unnecessary drugs.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> All residents admitted with an antipsychotic drug or a current resident with a new order for an antipsychotic drug will have an AIMS (Abnormal Involuntary Movement Scale) completed per policy. Residents #8 & #15 have had AIMS completed per policy. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents currently taking an antipsychotic drug are at risk. Audit completed by DNS/Designee on 7/18/2014 to ensure an AIMS is completed on all residents taking an antipsychotic drug. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> New admissions and current residents with new orders for antipsychotic drugs are reviewed by IDT the next business day to ensure that all residents with antipsychotic drug regimens are identified and AIMS completed. 	

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	<p>(AIMS) (an assessment for tardive dyskinesia) 2 times a year.</p> <p>The clinical record of Resident #8 contained an AIMS assessment completed on 6/18/14, 6 months and 4 days after Seroquel was started.</p> <p>During an interview with the Director of Nursing on 7/18/14 at 2:25 p.m., the DoN indicated the AIMS assessment completed on 6/18/14 was the only one completed for Resident #8. The DoN indicated Resident #8 should have had an AIMS assessment completed within 48 hours of the admission on 1/14/14.</p> <p>2. Resident #115's clinical record was reviewed on 7/16/2014 at 9:35 a.m. Diagnoses included, but were not limited to, dementia with delusions (mental disorder causing impairment in memory and judgement with abnormal perceptions that can be refuted), insomnia (inability to sleep), depression, and Parkinson's disease (neurological disease).</p> <p>Resident #115 was admitted 4/16/2014.</p> <p>Physician's order dated 4/16/2014, indicated Resident #115's original order for Seroquel (antipsychotic medication) was 25 milligrams (mg) twice a day.</p>		<ul style="list-style-type: none"> · ADNS/Designee conducted in-service on AIMS and psychotic medications for Licensed Nursing Staff by August 7, 2014. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Psychotic CQI Tool Audits to be completed for 10 residents weekly x 4 weeks, then 10 residents per month x 4 months. · Threshold of 95% will be maintained or an action plan will be developed. · Data will be submitted to the CQI Committee for review and follow up. <p>Compliance date: August 7, 2014</p>				

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	<p>Physician's order dated 5/30/2014, indicated the discontinuation of the original order of Seroquel.</p> <p>Physician's order dated 5/30/2014, indicated the new order for Seroquel was 12.5 mg in the morning and 25 mg at bedtime.</p> <p>No Abnormal Involuntary Movement Scale (assessment for a tardive dyskinesia, a common side effect of antipsychotic medication use) (AIMS) was found except for 5/21/2014.</p> <p>On 7/18/2014 at 2:50 p.m., the Director of Nursing (DoN) indicated, Resident #115 only had an AIMS assessment dated 5/21/2014.</p> <p>Resident #115's care plan for psychotropic medication initiated 4/29/2014, indicated, "AIMS assessments [to be completed] two times a year."</p> <p>On 7/18/2014 at 3:00 p.m., the DoN indicated the facility completed AIMS assessments according to the gradual dose reduction policy. He continued to indicate, the policy instructs the facility to complete AIMS assessments within 48 hours of a new order for an antipsychotic and when new residents are admitted on</p>			

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F000412 SS=D	<p>an antipsychotic.</p> <p>On 7/14/2014 at 11:15 a.m., the DoN provided the ASC Psychotropic Medication Management Program, undated, and indicated the policy was the one currently used by the facility. The policy indicated, "An AIMS assessment is required for residents who are taking antipsychotic medication. The assessment should be completed within 48 hours of a new order to initiate an antipsychotic and then every six months."</p> <p>3.1-48(a)(3)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident having a loose fitting denture was scheduled to see the dentist for a follow up appointment for 1 of 2 residents meeting the criteria for dental</p>	F000412	<p><u>F-412</u></p> <p>The facility does provide or obtain from an outside resource, routine, and emergency dental services to meet the needs of each resident.</p>	08/07/2014			

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	<p>review. (Resident # 7)</p> <p>Findings include:</p> <p>The clinical record of Resident #7 was reviewed on 7/17/14 at 12:30 p.m. Diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), Alzheimer's disease, hypertension (high blood pressure), and schizophrenia (a mental health condition which causes abnormal thinking).</p> <p>A quarterly MDS, completed 1/14/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 6, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. Section L "Oral/Dental Status" of the quarterly assessment lacked documentation of assessment.</p> <p>A quarterly MDS, completed 4/14/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 6, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. Section L "Oral/Dental</p>		<p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> Resident #7 still resides in the facility & the care-plan has been accurately updated. Resident's POA has been contacted regarding loose fitting dentures. Resident's POA has determined that no further follow up is needed and does not want resident #7's dentures adjusted any longer due to resident #7 having no chewing/swallowing issues, no weight issues and not wanting to wear dentures. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents needing dentures have the potential to be affected. DNS/designee conducted an audit of residents with dentures in the facility and the physician's order to ensure residents are receiving denture care per physician order on August 7, 2014. DNS/designee have interviewed and assessed all residents with dentures. Any identified as loose fitting will have dentist notified on August 7, 2014. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ADNS/designee will in-service 				

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	<p>Status" of the quarterly assessment lacked documentation of assessment.</p> <p>A annual MDS, completed 7/8/14, assessed Resident #7 as Brief Interview for Mental Status (BIMS) of 5, indicating moderate cognitive impairment. The MDS assessed Resident #7 as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene including brushing teeth. In Section L "Oral/Dental Status" of the annual assessment, Resident #7 was assessed as "None of the Above." Number A in Section L indicated "... Broken or loosely fitting full or partial denture...."</p> <p>During a Stage 1 family interview on 7/15/14 at 12:30 p.m., a family member expressed concern that Resident #7 had difficulty chewing food due to a loose fitting upper denture. The denture was described as loose and frequently falling down while Resident #7 was eating. The family member indicated the concern with the loose fitting denture had been mentioned to the staff "some time ago," but the denture remained loose fitting.</p> <p>During an interview with the Social Services Director (SSD) on 7/16/14 at 4:15 p.m., the SSD indicated Resident #7 was seen by the facility dentist on</p>		<p>the nursing staff on denture care and ensuring that any loose fitting dentures are notified to supervisor upon discovery on <i>August 7, 2014</i>.</p> <ul style="list-style-type: none"> · DNS/Designee to assess all new residents & residents with weight loss to ensure denture needs are met and care-plan is accurately developed. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · A CQI tool will be utilized to determine if a resident's dentures are fitting properly 10 per week x4 weeks, then monthly x 3 months and then quarterly x 2. · Threshold of 95% will be maintained or an action plan will be developed. · Data will be submitted to the CQI Committee for review and follow up. If threshold is not met an action plan will be developed. <p>Compliance date: <i>August 7, 2014</i></p>				

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	<p>12/18/13. The SSD provided a copy of "PrevMed Communication Sheet" dated 12/18/13. Resident #7 was listed on the communication sheet with documentation indicating the resident needed a reline of the denture. The PrevMed Dental Progress Note, dated 12/18/13, indicated Resident #7 was advised to use adhesive to the denture until assessment was completed for a reline.</p> <p>A nursing progress note, dated 1/25/14 at 10:44 p.m., indicated Resident #7 had denture "drop down from palate" during an episode of anxiety.</p> <p>During an interview with the SSD on 7/16/14 at 4:15 p.m., the SSD provided a copy of "Dentist Daily Billing Report" for service date 2/26/14, indicating Resident #7 was delivered a denture which had been relined. The SSD indicated the resident had not been seen by the dentist since 2/26/14.</p> <p>During review of an "Observation Report" for Resident #7, dated 2/28/14 at 8:54 p.m., under "Oral Status" Resident #7 was assessed as having broken or loosely fitting full or partial denture.</p> <p>During a review of the care plan and interventions for Resident #7, Resident #7 had a problem category of self care</p>						

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	<p>deficit with an intervention to provide oral care twice a day. The careplan lacked documentation indicating Resident #7 had an upper denture.</p> <p>During a review of the recapitulation of physician's orders for Resident #7, dated July 2014, Resident #7 was prescribed a mechanical soft diet.</p> <p>During an observation of Resident #7 on 7/17/14 at 12:00 p.m., Resident #7 was observed eating lunch without a denture in place.</p> <p>During an interview with the Memory Care Facilitator on 4/17/14, at 12:10 p.m., the Memory Care Facilitator indicated Resident #7 should have denture in place at mealtimes. Resident #7 was asked if she wanted to put in her denture and she indicated she did. Resident #7 was assisted to her room by CNA #2.</p> <p>During an interview with CNA #2 on 7/17/14 at 12:10 p.m., CNA #2 indicated Resident #7 preferred to leave upper denture out as the denture was very loose and would not stay in place, especially at mealtimes. CNA #2 indicated adhesive was used to try to help secure the denture, but the denture would still fall down when the resident was trying to eat. CNA</p>			

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	<p>#2 rinsed the denture plate, applied an adhesive to the plate, and handed the denture in a container to Resident #7. When asked to place the denture in her mouth Resident #7 stated, "They are too loose and keep falling out. I would rather eat with what I have." (Resident #7 pointed to her natural teeth on her bottom gum.) CNA #2 indicated Resident #7 had seen the dentist regarding the loose fitting plate, but the denture remained too loose.</p> <p>During an interview with the Director of Nursing and the Memory Care Facilitator on 7/17/14 at 4:22 p.m., the DoN indicated the "Resident Profile" was utilized as an assignment sheet for the certified nursing assistants (CNA). A review of the Resident Profile for Resident #7 indicated Resident #7 was to be provided with oral care twice a day, but lacked documentation indicating Resident #7 had an upper denture. The Memory Care Facilitator indicated the dental staff have a schedule of residents to see with each visit, but residents who have a need to see the dentist can be added to the schedule as late as the date of the dental visit. The Memory Care facilitator indicated she did not know Resident #7 had a loose denture and would add her to the schedule for the next dental visit.</p>						

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F000441 SS=D	<p>3.1-24(a)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin 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>			

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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered without contamination for 1 random observation of medication preparation in that the nurse touched the pills prior to putting the pills in the medication administration cups. (Resident #141) (RN #1)</p> <p>Findings include:</p> <p>On 7/18/14 at 10:50 a.m., RN #1 was observed on Unit D standing at a medication cart. She was observed picking up a medication blister pack (medication pill card with doses of medication located in individual compartments), dispensed the pills into her hand, and then placed the pills into multiple medication cups. The medication cart drawer was opened slightly. She pulled out the medication cart drawer further and placed the medication blister pack back into the drawer and picked up another medication blister pack. She continued to dispense the second blister pack's pills into her hand and placed the pills into the medication cups with the other pills. RN #1 was observed to perform the same</p>	F000441	<p>F-441</p> <p>The facility strives to maintain the Infection Control Program ensuring that all residents are provided with a sanitary, safe environment to help prevent the development and transmission of disease and infection.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> · RN #1 was provided one on one coaching by ADNS on Infection Control Policy and Medication Preparation Policy as well as medication administration competency validation test. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected. · Licensed Nurses educated by the ADNS/designee on Infection Control Policy and Medication Procedure Policy by August 7, 2014. · Medication pass skills validation completed with Licensed Nursing Staff by ADNS/Designee August 7, 2014. 	08/07/2014

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	<p>action with a total of three blister packs.</p> <p>On 7/18/14 at 10:55 a.m., RN #1 indicated she had been dispensing the medication into her hand, but had washed her hands at the beginning of the medication preparation. She indicated, she does not normally prepare medications like this. She would normally dispense the medication directly into the medication cups.</p> <p>RN #1 continued to indicate, she was preparing three days of medications for Resident #141 to take home at discharge.</p> <p>On 7/18/14 at 11:00 a.m., the Director of Nursing (DoN) indicated, the facility's practice is to dispense the medication from a blister pack into the medication cup, not into the hand of the person dispensing the medication.</p> <p>On 7/18/14 at 1125 a.m., the DoN provided the Medication Pass Procedure, dated 03/2013, and indicated the procedure was the one currently used by the facility. The procedure indicated, "... 3. Medications are opened without contaminating...."</p> <p>On 7/18/14 at 1:30 p.m., the DoN indicated, he would not prepare medications in this manner. All the</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · All residents have the potential to be affected. · Licensed Nurses educated by the ADNS/designee infection Control Policy and Medication Procedure Policy by August 7, 2014. · DNS/Designee to complete rounds during each shift sporadically to ensure proper infection control techniques are used during medication administration. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · Infection control CQI tool weekly x 4 weeks, then bi-weekly x 4 months and quarterly thereafter until compliance is maintained for 2 consecutive quarters. · The result of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance <p>Compliance date: August 7, 2014</p>	
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	medications that RN #1 had dispensed using her hands had been disposed of and new medications were dispensed to send home with Resident #141 that no one had touched. 3.1-18(l)				