

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155656	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
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NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey</p> <p>Survey dates: February 24, 25, 26, 27 and March 2, 2015</p> <p>Facility number: 000275 Provider number: 155656 AIM number: 100290930</p> <p>Survey team: Tim Long, RN-TC Rick Blain, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census Payer type: Medicare: 12 Medicaid: 73 Other: 13 Total: 98</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 4,</p>	F 000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review. We have included our re-education and monitoring tools for your convenience. Please feel free to contact Maya Kaczmarek at 260-580-6025 should you need additional information to assist you with your consideration.</p>	

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

TITLE

(X6) DATE

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

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F 176 SS=D Bldg. 00	<p>2015 by Randy Fry RN.</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an assessment for self-administration of medications was completed for 1 of 7 residents, Resident #3, who was observed during medication observation, and whose medication was left at bedside without nursing observation.</p> <p>Findings include:</p> <p>RN# 3 was observed during a medication pass, on 2/27/15, at 8:10 A.M. The RN was observed giving medication to Resident #3, at 8:20 A.M., on 2/27/15. She had placed Miralax powder 17 grams in a plastic glass, and along with other medications she had prepared for the resident, took the medications into the resident's room. The resident, who was observed eating her breakfast, took the other medications with the RN present. The RN then left the plastic glass containing the Miralax powder on the resident's bedside table, and left the</p>	F 176	<p>Corrective action for alleged deficient practice:</p> <ol style="list-style-type: none"> Resident #3 received assessment of self administration and orders obtained. Care plan updated to reflect change. <p>Identification of others with potential to be affected by alleged deficient practice:</p> <ol style="list-style-type: none"> All residents have potential to be at risk. 100% review will be completed on residents to identify residents requiring self administration assessments with follow-up per policy. <p>Systematic changes in place for alleged deficient practice:</p> <ol style="list-style-type: none"> Licensed nurses will be re-educated on policy regarding self administration policy. <p>How corrective action will be monitored to ensure alleged deficient practice does not reoccur:</p> <ol style="list-style-type: none"> Nurse Managers will review residents with potential for self administration needs quarterly with OBRA assessments to ensure policy is followed and address identified 	03/30/2015

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	<p>room. The RN indicated the resident would add the liquid and take the medication herself after eating her breakfast.</p> <p>The record for Resident #3 was reviewed, on 2/27/15, at 9:10 A.M. A physician's order indicated Miralax Powder, give 17 grams in 8 ounces of fluid, orally once a day. There was no physician's order to keep the medication at bedside or leave the medication for the resident to take on her own. There was also no care plan to indicate the medication was to be left at the bedside.</p> <p>The DNS was interviewed, on 3/2/15, at 10:18 A.M., and indicated there was no physician order for May Keep at Bedside Medications for the Miralax, and no assessment completed to keep the medication at bedside</p> <p>The current policy for Self-Medication Assessment and Management, dated as most recently revised on April 2006, was provided by the Administrator, on 2/27/15, at 11:20 A.M.</p> <p>The policy was reviewed, on 2/27/15, at 11:35 A.M., and included, but was not limited to the following: "Review and analyze interdisciplinary assessments to determine the resident's ability to self-medicate; Complete the Self-Medication Data</p>		<p>issues. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs. Any identified trends will be forwarded to the administrator for review for further education and/or termination as needed and presented to QA for further needs.</p> <p>Date of compliance: 3/30/15</p>	

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F 325 SS=D Bldg. 00	<p>Collection and Assessment; Complete the Self-Medication Data Collection and Assessment form with change in condition and quarterly; Evaluate the resident's self-medication status at each care plan review meeting." 3.1-11(a)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review, and interview, the facility failed to ensure weekly weights were completed upon admission according to the facility weight monitoring policy, failed to ensure a monthly weight was recorded, and failed to ensure weekly weights were completed as per the Registered Dietician (RD) recommendation, after a significant weight loss. This affected 1 of 3 residents</p>	F 325	<p>Corrective action for alleged deficient practice: 1. Resident #168 has received full assessment of nutritional needs by RD. Identification of others with potential to be affected by alleged deficient practice: 1. All residents have potential to be at risk. 2. All in-house residents will receive review of weights from</p>	03/30/2015

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	<p>reviewed for Nutrition, Resident #168.</p> <p>Findings include:</p> <p>The Weights Detail Reports(from the facility computer Care Tracker) were provided to surveyors during Stage 1 of the survey, on 2/24/15. The reports contained all the weights for Stage 1 residents.</p> <p>The only weights listed for Resident #168 were as follows:</p> <p>11/22/14 at 1:47 P.M. - 252 1/7/15 at 11:35 A.M. 223 2/12/15 at 10:53 A.M. 222. 5 2/12/15 at 4:35 P.M. 222. 5</p> <p>Resident # 168 was observed sitting in the main dining room, on 2/26/15, at 12:15 P.M., feeding himself lunch. QMA #1 was interviewed, on 2/26/15, at 2:40 P.M., and indicated the resident fed himself meals, he had a good appetite, and a family member brought him snacks all the time.</p> <p>The record for Resident #168 was reviewed, on 2/27/15 at 11:25 A.M., and indicated the resident was admitted on 11/21/14.</p> <p>A nursing note, dated 11/23/14, indicated the resident was able to make his needs known, and had no edema.</p> <p>A physician's order, dated 11/23/14,</p>		<p>January 2015 through current to ensure weights have been obtained and documented per policy. Any residents identified with deficiencies will have nutritional status assessed by RD.</p> <p>3. A 1 x weight audit will be completed on all w/c and/or adapted device(s). Systematic changes in place for alleged deficient practice:</p> <p>1. Licensed nursing staff will be re-educated on Weight Monitoring policy.</p> <p>2. UM and/or designee will review assigned residents daily/weekly/monthly for weight needs. Ensure all needed weights are entered into care tracker per policy.</p> <p>3. DON/designee will keep master w/c and or/adaptive device weight log and ensure updated as necessary.</p> <p>4. DON/designee will review weights entered into care tracker daily/weekly/monthly for significant changes to be given to registered dietician for recommendations. How corrective action will be monitored to ensure alleged deficient practice does not reoccur:</p> <p>1. Nurse Managers will review all new admissions and readmissions weekly to ensure weights monitored per policy. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs. Any identified</p>	

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	<p>indicated the resident was to receive Speech Therapy for memory, problem solving, organization, safety awareness, swallowing strategies and exercises.</p> <p>The Nutrition Risk Data Collection and Assessment, dated 11/21/14, and documented by the Registered Dietician (RD), indicated the resident weighed 252 pounds, with typical intakes of 100%, the resident had no chewing or swallowing problems, fed himself with supervision, and was alert and oriented to person, and at times to place and time. The assessment summary indicated the resident was on a CCHO (controlled carbohydrate) diet, would request NAS (no added salt) modification to aid in preventing fluid retention, appetite was good, and would encourage diet adherence to stabilize blood sugars within normal limits.</p> <p>The next Nutrition Risk Data Collection Assessment, dated 1/23/15, indicated the resident's weight was 223 pounds, a 29 pound weight loss. The resident remained on the CCHO diet, required set up and supervision to feed himself, appetite was good, and there were no swallowing or chewing problems. The note further indicated the weight change might be due to better blood sugar and fluid level</p>		<p>trends will be forwarded to the administrator to review for further education and/or termination as needed and presented to QA for further needs.</p> <p>Date of Compliance: 3/30/15</p>		

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	<p>control, would continue to monitor routinely, and would request weekly weights to monitor for additional changes.</p> <p>There were no weekly weights found in the record.</p> <p>The Registered Dietician (RD), was interviewed on 2/27/15, at 11:35 A.M., and indicated she did not know why there was a weight difference as the resident was eating well. She indicated possibly the resident could have been weighed in a wheelchair, and whoever weighed him did not subtract the weight of the wheelchair, but she did not know if this was what happened. She also indicated there was no documented weight for December 2014, so a month was missed.</p> <p>The Director of Nursing Services was interviewed, on 2/27/15, at 12:50 P.M., regarding the weight loss. She indicated weekly weights were supposed to be done for 4 weeks when residents were first admitted. She indicated the former Nurse Manager was supposed to put weights into the Care Tracker and was also supposed to indicate in the Care Tracker if weekly weights were to be done. The DNS indicated she discovered in January, 2015, this was not being done.</p>			

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	<p>The DNS was interviewed, on 3/2/15, at 8:20 A.M., and indicated the resident's food intakes were good, the resident had always eaten very well. She indicated she had found a discharge summary form the hospital the resident was admitted from which showed a weight of 208 pounds. The discharge summary, dated 11/20/14 was provided by the DNS, on 3/2/15, at 8:30 A.M., and reviewed on 3/2/15, at 8:35 A.M. The summary indicated the resident was being discharged, and indicated the last recorded weight was 208 pounds on 11/1/14.</p> <p>The DNS also provided a 400 hall report sheet updated 11/21/14, on 3/2/15, at 8:30 A.M., which was reviewed with the DNS, at 8:30 A.M., on 3/2/15. The report sheet indicated at the top, December or November and weights for various residents, including Resident #168, were listed on the report sheet. The weight indicated 254.5 pounds for this resident, and after the weight there was an arrow with wc(wheelchair) which had been circled with a question mark after the wc. The DNS indicated this was the unit manager's writing and she had questioned if this was a wheelchair weight. The DNS indicated the resident had always had the same wheelchair and indicated the wheelchair weighed 39 pounds, but</p>			

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	<p>also indicated the actual weight had never been transcribed. She further indicated the monthly weight for March, 2015 was 225 pounds</p> <p>The DNS indicated at the end of January, 2015, she had identified a concern with the previous restorative nurse manager. She indicated part of the assigned duties of the restorative nurse manager was to oversee the weight monitoring program. She indicated in January, 2015, she realized this was not being done. She indicated when a resident was first admitted, weekly weights were to be completed for 4 weeks. She indicated none of the weekly weights were done for Resident #168, as the restorative nurse manager did not add the resident's name to the logs for weekly weights.</p> <p>The Weight Monitoring policy, dated as most recently revised on October, 2014, was provided by the DNS, on 3/2/15, at 8:45 A.M.</p> <p>The policy was reviewed, on 3/2/15, at 9:00 A.M., and indicated the following: Weigh each resident within 24 hours of admission and readmission, preferably on the shift when the admission occurred. Weigh the resident weekly for four weeks and/or until the weights were determined to be stable by the Interdisciplinary Team following admission and readmission. Verify accuracy of the weight by</p>			
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F 332 SS=D	<p>comparing the weight with the most recently recorded weight. Compare weights using the Weight Change Grid to determine 3% weight change. Supervise the CNA while re-weighing the resident to assure that correct process is followed, if the weight had changed with a gain or loss of 3% or greater. Monitor weight reports for significant changes and for gradual insidious changes that might indicate a risk factor for nutrition or hydration status and/or clinical condition. Document weight using Care Tracker. Report changes of 3% or more on the 24 hour report for review in the Daily Triage meeting and possible follow-up at the Daily Clinical review meeting. Notify the RD. Review significant weight change reports daily for review in Daily Triage meetings. Review the weight reports at least weekly to assure that all residents with significant weight change were reviewed and assessed for nutrition risk factors.</p> <p>3.1-46(a)(1)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES</p>				

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Bldg. 00	<p>OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility was free of a medication error rate of 5% or less. There were 2 medication errors in an opportunity of 29, which was a 6.9% error rate.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The medication pass was observed on 2/26/15, at 4:05 P.M. QMA #1 was noted to give Acetaminophen 325 milligrams (mg), 2 tablets, by mouth, to Resident #41, along with the residents other medication. The QMA did not inquire if the resident had any pain or the location of the pain. The Physician orders for Resident #41 were reviewed, on 2/27/15, at 9:35 A.M., and indicated an order for Acetaminophen 325 mg. give 2 tablets, by mouth every 4 hours as needed for pain. The Medication Administration Record (MAR) for February 2015, indicated the resident had been receiving routine Acetaminophen 325 mg. 2 tablets, at 8:00 A.M., 12 noon, and 5:00 P.M., but this order had been discontinued on 2/19/15. There was no documentation on the MAR to indicate any Acetaminophen had been given to 	F 332	<p>Corrective action for alleged non-compliance related to ensuring the facility was free of a medication errors:</p> <ol style="list-style-type: none"> QMA #1 received 1:1 education regarding Medication Administration policy. RN #3 is no longer an employee of facility. Identification of others with potential to be affected by alleged deficient practice: <ol style="list-style-type: none"> All residents receiving medications are at risk. Systematic changes in place for alleged deficient practice: <ol style="list-style-type: none"> Licensed nurses and QMAs will be re-educated on medication administration policy. <p>How corrective action will be monitored to ensure alleged deficient practice does not reoccur:</p> <ol style="list-style-type: none"> ETD/designee will perform medication administration competencies/observations with licensed nurses to ensure medications administered per policy. <ol style="list-style-type: none"> ETD/designee will perform medication administration competencies/observations weekly x 4 weeks with 5 licensed nurses and/or QMAs then twice a month with 5 licensed nurses and/or QMAs for two months, and then monthly with 5 licensed nurses and /or QMAs for three months to ensure 	03/30/2015

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	<p>the resident after 2/19/15. LPN #2 was interviewed, on 2/27/15, at 9:45 A.M., and indicated if a QMA gave PRN (as needed) medication to a resident, the QMA was supposed to check with the nurse prior to giving the medication. The LPN indicated the QMA was supposed to go back to the resident after 45 minutes to 1 hour to see if the pain was relieved. The LPN indicated the QMA was also supposed to document the location of the pain, the rating of the pain, and if the pain was relieved on the PRN analgesic record.</p> <p>The February, 2015, PRN Analgesic Record for Resident #41 was reviewed, on 2/27/15, at 9:50 A.M., and was blank.</p> <p>2. RN# 3 was observed during a medication pass, on 2/27/15, at 8:10 A.M. The RN was observed giving medication and eye drops to Resident #3, at 8:20 A.M., on 2/27/15. She placed one drop of Restasis eye drops 0.05%, in each of the resident's eyes. She handed the resident her oral medications which the resident took herself. The RN waited 2-3 minutes then placed one drop of Genteal eye drops in each of the resident's eyes.</p> <p>The record for Resident #3 was reviewed, on 2/27/15, at 9:15 A.M. Physician</p>		<p>medications administered per policy. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator to review for further education and/or termination as needed and presented to QA for further needs.</p> <p>Date of Compliance: 3/30/15</p>	

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	<p>orders indicated an order for Restasis 0.05% eye emulsion, instill 1 drop into each eye 2 times a day, and indicated to wait 15 minutes between eye meds.</p> <p>Another physician order indicated Genteal eye drops, instill 1 drop into each eye 6 times a day, and wait 5 minutes between eye meds.</p> <p>A policy for Medication Administration, dated as revised most recently on November, 2012, was provided by the Director of Nursing Services (DNS), on 3/2/15, at 8:45 A.M.</p> <p>The policy was reviewed, on 3/2/15, at 9:00 A.M., and indicated the following: The licensed nurse and/or medication assistant will check the following to administer medication: Right medication Right dose Right dosage form Right route Right resident Right time.</p> <p>The policy also indicated documentation was to be completed on the Medication Administration Record as soon as the medications were given.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F 431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>			

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	<p>Based on observation, interview, and record review, the facility failed to ensure a RN disposed of a medication kept in the narcotic drawer according to facility policy, failed to ensure a medication was labeled with a resident's name, and failed to ensure an expired bottle of insulin was removed from the medication cart. This affected 2 residents observed during medication pass, Resident's #3 and 25, and one resident observed during Med Storage observation, Resident #143.</p> <p>Findings include:</p> <p>1. RN# 3 was observed during a medication pass, on 2/27/15, at 8:10 A.M. The RN was noted to take a bubble pack of Diazepam (for anxiety) for Resident # 3 out of the narcotic drawer. She removed Diazepam 5 milligrams (mg) from the bubble pack, and placed the tablet in a medication cup. When she realized the Diazepam was not supposed to be given at this time, she replaced the tablet back into the bubble pack, taped it, then replaced the bubblepack back in the locked narcotic drawer.</p> <p>RN #3 then prepared medications for Resident #25. She got in the medication cart and picked up a Symbicort inhaler, but the inhaler was not labeled with a resident name. The RN indicated she</p>	F 431	<p>Corrective action for alleged non-compliance of disposing of a medication in narcotic drawer, ensuring medication labeled with resident's name and ensuring expired bottle of insulin was removed from medication cart. 1. RN #3 is no longer an employee of facility. 2. Resident #25 received new, properly labeled inhaler from pharmacy. 3. Resident #143 received new Lantus insulin vial from pharmacy. Identification of others with potential to be affected by alleged deficient practice: 1. All residents are at risk for inaccurate drug records, labeling, and storage of drugs and biologicals. Systematic changes in place for alleged deficient practice: 1. Licensed nurses and QMAs will receive re-education on policy pertaining to disposing of medications, medication labeling and what to do with expired medications per policy. How corrective action will be monitored to ensure alleged deficient practice does not reoccur: 1. All medication carts will receive 1 x audit to ensure medications are labeled, disposed of properly and expired medications are disposed of per policy. 2. ETD/designee will perform cart audits weekly x 4 weeks, then bi-monthly for two months, and then monthly for three months to ensure medications are properly stored, disposed of and labeled per policy</p>	03/30/2015

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	<p>would not give the medication at this time because it was not labeled and she was not sure it belonged to Resident #25.. She indicated she would have to order a Symbicort inhaler for the resident since the inhaler was not labeled.</p> <p>The record for Resident #25 was reviewed, on 2/27/15, at 9:00 A.M. Physician orders indicated Symbicort 80-4.5 mcg inhaler, inhale 2 puff orally 2 times a day.</p> <p>The record for Resident #3 was reviewed, on 2/27/15, at 9:15 A.M. Physician orders indicated Diazepam 5 milligrams, give 1 tablet orally at bedtime.</p> <p>The medication cart was checked, with the Director of Nursing Services (DNS), on 2/27/15, at 11:15 A.M. The DNS pulled the Diazepam which had been taped by RN #3 and indicated it was not facility policy to tape a medication which was pulled but not given. She indicated the Diazepam should have been destroyed.</p> <p>The medication cart on 200 hall was checked with the Assistant Director of Nursing Services (ADNS), on 3/2/15, at 11:40 A.M. A Symbicort 80-4.5 mcg inhaler was located in the medication cart with no</p>		<p>with immediate correction of identified issues. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs. Any identified trends will be forwarded to the administrator to review for further education and/or termination as needed and presented to QA for further needs. Date of compliance: 3/30/15</p>				

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	<p>label on the inhaler. A piece of notebook paper was wrapped around the inhaler with writing on the paper which indicated, "found in (Resident #25's) room no name on inhaler" The ADNS indicated she didn't know who wrote the note.</p> <p>The MAR for February and March, 2015, was reviewed, and indicated the medication was circled on 2/27/15 at 9:00 A.M., with an explanation on the back of the MAR, which indicated the medication was not given. The MAR for February, 2015, indicated the medication was given on 2/27/15 at 9:00 P.M., and on 2/28/15, at 9:00 A.M., and 9:00 P.M. The MAR for March 2015, indicated the medication was given at 9:00 A.M., and 9:00 P.M., on 3/1/15, and at 9:00 A.M., on 3/2/15.</p> <p>There was also a bottle of Lantus insulin found in the medication cart, for Resident # 143. The label on the bottle indicated the insulin was opened on 1/17/15, and expired on 2/15/15. The ADNS indicated the insulin should have been destroyed after 30 days per facility policy.</p> <p>The ADNS phoned the pharmacy regarding the Symbicort for Resident #25, on 3/2/15, at 12:15 P.M. She indicated the pharmacy had received an order for the Symbicort on 2/27/15, but</p>			

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	<p>the medication would not be delivered until 3/2/15 in the evening.</p> <p>The record for Resident #143 was reviewed, on 3/2/15, at 3:45 P.M. Physician orders indicated Lantus insulin, inject 16 units sub-q at bedtime. The Medication Administration Record for February, 2015, indicated the insulin had been given at 8:00 P.M. on 2/15 through 2/27/15. The MAR for March 2015, indicated the medication was given on 3/1/15 at 8:00 P.M.</p> <p>The policy for Destruction of Controlled Drugs, dated as most recently revised on October, 2013, was provided by the Director of Nursing Services (DNS) on 3/2/15, at 8:45 A.M. The policy was reviewed, on 3/2/15, at 9:00 A.M., and indicated the following: Destroy all controlled substances, wasted, contaminated, expired or refused medication in the presence of two licensed nurses designated by the DNS or according to state regulation.</p> <p>The policy for Medication Administration, dated as most recently revised on November 2012, was provided by the DNS, on 3/2/15, at 8:45 A.M. The policy was reviewed, on 3/2/15, at</p>			

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F 441 SS=D Bldg. 00	<p>9:00 A.M., and indicated the following: Verify the pharmacy prescription label on the drug and the manufacturer's identification system matches the MAR.</p> <p>The policy for Insulin Injection, dated as most recently revised on April 2006, was provided by the Regional Nurse Consultant, on 3/2/15, at 3:45 P.M. The policy was reviewed, on 3/2/15, at 3:50 P.M., and indicated the following: Inspect the bottle for type of insulin and expiration date.</p> <p>The DNS was interviewed, on 3/2/15, at 3:52 P.M., and indicated although the policy did not indicate how many days an opened bottle of insulin was used before discarding, the facility policy was to discard the insulin after 28 days.</p> <p>3.1-25(j)(k)(l)</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>			

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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(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.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, and record review, the facility failed to ensure handwashing was completed by a staff member before and after glove removal . This affected 1 of 1 Residents (Resident #3), who was given eye medications during a medication pass.</p> <p>Findings include:</p>	F 441	<p>Corrective action for alleged non-compliance handwashing before and after glove removal:</p> <p>1. RN #3 is no longer an employee of facility. Identification of others with potential to be affected by alleged deficient practice: 1. All residents receiving eye drops are at risk. Systematic changes in place for alleged deficient practice: 1. Licensed nurses and QMAs will</p>	03/30/2015

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	<p>RN# 3 was observed during a medication pass, on 2/27/15, at 8:10 A.M.</p> <p>The RN was observed giving medication and eye drops to Resident #3, at 8:20 A.M. She donned gloves, without washing her hands, and placed one drop of Restasis eye drops in each of the resident's eyes. She handed the resident her oral medications which the resident took herself. The RN removed the gloves, and donned another pair of gloves, without washing her hands. She waited 2-3 minutes then placed one drop of Genteal eye drops in each of the resident's eyes. The RN then removed the gloves, but did not wash her hands.</p> <p>The RN was observed to use a hand sanitizer to cleanse her hands before preparing medication for another resident.</p> <p>The Procedure for Eye Drops policy, dated as most recently revised n July 2010, was provided by the Administrator, on 2/27/15, at 11:20 A.M.</p> <p>The policy was reviewed, on 2/27/15, at 11:30 A.M., and indicated the following: Standard precautions would be observed throughout the procedure; and included , but was not limited to the following: Wash hands; Don clean gloves; Place the prescribed number of drops into</p>		<p>receive re-education on eye drop administration and hand washing per policy. How corrective action will be monitored to ensure alleged deficient practice does not reoccur: 1. ETD/designee will perform observations of eye drop administration and hand washing on 5 residents/staff weekly x 4 weeks, then bi-monthly for two months, and then monthly x three months to ensure eye drop administration and hand washing per policy with immediate correction of identified issues. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator to review for further education and/or termination as needed and presented to QA for further needs. Date of compliance: 3/30/15</p>	

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F 463 SS=E Bldg. 00	<p>the lower lid pouch; Wipe around the eye with tissue if any excess drops or tearing; Wash hands and apply new clean gloves, if administering medication to the other eye; Remove gloves and discard; Wash hands.</p> <p>3.1-18(l)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, record review, and interview, the facility failed to ensure call lights were fully operational in resident bathrooms. This affected 2 of 5 halls in the facility.</p> <p>Findings include: Resident #2 was interviewed, on 2/25/15, at 9:35 A.M., and indicated call lights in the resident rooms and bathrooms sometimes did not light up, especially in the evenings. She indicated she had reported this (could not remember when) to a staff member, and was told that sometimes when other lights in hall were</p>	F 463	<p>Corrective action for alleged deficient practice: 1. Residents on 200 & 400 halls were given bells until call lights were repaired and tested2. Designated staff member conducted walking rounds until the call light system was repaired and tested. 3. The call lights were professionally repaired and tested 3.3.15Identification of others with potential to be affected by alleged deficient practice: 1. 100% review was completed of resident call lights to identify residents who are having call light issues. Systematic changes in place for alleged deficient practice: 1. Administrator or designee to conduct weekly call light audits</p>	03/03/2015

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	<p>on, the resident's light would not come on right away. Resident #2 could not remember who she had reported this concern to regarding the call lights.</p> <p>Call lights were checked on all the units of the facility, with the Director of Environmental Services, and Housekeeping Supervisor, on 3/2/15, at 10:30 A.M.</p> <p>When the Director of Environmental Services, and the Housekeeping Supervisor checked the emergency call lights in resident bathrooms, the following was noted:</p> <p>Room 201 - call light indicator over the resident's door did not come on, when pulled call light in bathroom;</p> <p>Room 206 - light indicator over door lit</p> <p>Room 207 - light indicator over door lit</p> <p>Room 208 - light indicator did not come on when pulled and in room 206 the light went off, then in Room 208, the light came on then went right off again.</p> <p>Room 207 - the light indicator went off when the call light in Room 208 came on again.</p> <p>Room 202 - the light indicator did not come on when pulled.</p> <p>Other call lights in the resident bathrooms on 200 hall were checked by the Environmental Director and the same thing occurred, when one call light lit</p>		<p>involving the turning on of multiple lights both in the restrooms and resident rooms to observe for deficiencies on all halls. How corrective action will be monitored to ensure alleged deficient practice does not reoccur: 1. Administrator or designee will review residents with call light concerns daily to ensure policy is followed and address identified issues. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs.</p>	

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	<p>over the door, another call light which had been pulled , would not light or would cause the other light which was lit to go off over the resident door.</p> <p>The emergency call lights in resident bathrooms on 400 hall were checked on 3/2/15, at 10:55 A.M. Room 402 and 403 - the light indicators over the door lit when checked; Room 405 - light indicator did not come on when checked, but when this light was pulled in the bathroom, the light indicators over the door in rooms 402 and 403 were no longer lit.</p> <p>The Environmental Director then shut the above lights off, and pulled the call lights in Room 402 and 407, which worked, but when he pulled the call light in Room 406, the indicator light did not come on, and both the indicator lights over Rooms 402 and 407 were no longer lit. :</p> <p>The Environmental Director indicated there was probably a problem with the wiring in the pull stations and indicated, it seemed like if more than 2 call lights were on, it would shut the other call lights off on the hall.</p> <p>The Environmental Director indicated, on 3/2/15, at 11:05 A.M., he had called the company that was responsible for the call light system, and they would be at the facility within the next hour.</p>			

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	<p>The Administrator was interviewed, on 3/2/15, at 11:10 A.M., and indicated she would get call bells for the residents on 200 and 400 hall until the call light system was fixed.</p> <p>The Administrator was interviewed, on 3/2/15, at 2:30 P.M., and indicated the representative from the company responsible for the call lights, had come to the facility this afternoon, and checked the call light system. She indicated parts had to be ordered, and the call light system would be fixed on 3/3/15. She indicated call bells would be given to all the residents affected, and a monitor would be put in place around the clock until the call light system was fixed.</p> <p>The Administrator provided a Facilities Management Audit, dated 1/21/15, on 3/2/15 at 2:30 P.M. The audit was reviewed, on 3/2/15, at 2:30 P.M., and indicated an audit of the entire nurse call system was tested and logged weekly.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>				