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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>10/05/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>PINE KNOLL ASSISTED LIVING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>607 WILSON CREEK RD<br>LAWRENCEBURG, IN47025 |
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| R0000              | <p>This visit was for a State Residential Licensure Survey.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00093566 completed 8-1-11.</p> <p>Survey dates: October 3, 4 and 5, 2011</p> <p>Facility number: 001142<br/>Provider number: 001142<br/>AIM number: N/A</p> <p>Survey team:<br/>Penny Marlatt, RN, TC<br/>Cheryl Fielden, RN<br/>Jill Ross, RN<br/>Diana Sidell, RN</p> <p>Census bed type:<br/>Other: 19<br/>Total: 19</p> <p>Census payor type:<br/>Other: 19<br/>Total: 19</p> <p>Sample: 7<br/>Supplemental Sample: 2</p> <p>These state findings are cited in</p> | R0000         |   |                      |

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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| R0241   | <p>accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 12, 2011 by Bev Faulkner, RN</p> <p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br/>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview and record review, the facility failed to ensure physician orders were followed for the use of a corticosteroid nasal spray, failed to transcribe new physician directions for the same medication in a timely manner and failed to obtain clarification orders in a timely manner for this same medication for 1 of 5 residents observed during the medication pass observation (Resident #18) and failed to ensure admission orders were obtained in a timely manner for 1 of 5 residents reviewed for physician orders (Resident #12)</p> <p>Findings include:</p> <p>1. LPN #1 was observed during the medication pass observation on 10-4-11 at 9:40 a.m., preparing to administer Flonase</p> | R0241   | <p>1. Resident #18's order was clarified on 10-5-11 and Resident # 12's orders were reviewed and signed on 7-27-11 by the primary physician. The admission order policy was reviewed and revised to include timeliness of orders to be verified. an incidental order/physician order policy ws developed, and staff will be inserviced on 10-25-11. (See Attachments #1 and #2)2. All residents' charts will be reviewed to ensure all orders have been properly handled and any deficiencies will addressed to correct the deficiency.3. The newly developed admission check off list and check off sheet for new orders will be put into place and staff will be inserviced on 10-25-11.4. The new check off sheet for new orders and admissions will be turned in to the Administrator once all tasks are</p> | 10/25/2011           |   |

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|   | <p>0.05%. LPN #1 was observed to administer one spray in each nostril. LPN #1 indicated the resident's order was for one spray in each nostril at this time.</p> <p>Review of Resident #18's recapitulation orders for October 2011 indicated two separate orders for Flonase. The first order, with an original order date of 1-28-11, indicated Flonase 50 mcg (micrograms) 2 sprays in each nostril twice daily as needed for allergies. The second order, dated 9-20-11, indicated Flonase Nasal Spray, with no strength indicated, one spray in each nostril twice daily.</p> <p>A physician's office visit document, dated 9-12-11 and signed by the resident's physician, indicated to increase the Flonase to one spray in each nostril twice daily. The recapitulation order for October 2011, had this specific Flonase order hand written onto the recapitulation form and dated "9-20-11", 8 days later than the office visit form.</p> <p>In interview with the Nursing Supervisor on 10-5-11 at 9:00 a.m., she indicated the facility does not have a specific policy to indicate in what time frame to have new orders transcribed, but her expectation would be that this should occur within hours of receiving the order. She</p> |   | <p>completed. The nursing staff will be responsible for updating the Administrator during working hours on the status of the forms. The Administrator will monitor weekly X three (3) months and then PRN. If there is a deficient practice, the Administrator or her designee will handle the appropriate re-education and/or disciplinary action.</p> |   |  |   |  |

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|   | <p>indicated she did not have an excuse why there was a delay in transcribing the new order or for getting a clarification.</p> <p>In review of the Medication Administration Record (MAR), it indicated the physician's order for Flonase one spray in each nostril twice daily was not initiated until 9-20-11, eight days after the physician had indicated the change in dosage. Additionally, the "prn" order for the Flonase was indicated on the MAR for September, 2011 indicated it had been administered once each day on 9-2, 9-5, 9-6, 9-7, 9-10, 9-11, 9-12, 9-13, 9-14, 9-15, 9-16, and 9-19. The MAR indicated the "prn" order for Flonase had been administered twice daily on 9-17-11.</p> <p>In interview with LPN #1 on 10-4-11 at 1:40 p.m., she indicated the resident had hand-carried the physician visit information with the new orders back to the facility with her upon her return from the physician's visit on 9-12-11. In interview on 10-4-11 at 1:40 p.m., she indicated she had called the physician's office to verify these orders, but had not documented the verification anywhere. She did not indicate on what date this occurred. She indicated she has been unable to speak with anyone at the physician's office this week (3 weeks after the order was received) to verify the</p> |   |   |   |  |   |  |

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|   | <p>correct dosage. In interview with LPN #1 on 10-5-11 at 9:15 a.m., indicated the resident would be able to verify the doctor's orders. She indicated she would not be able to verify the orders until next week as the doctor would not be back until then. LPN #1 indicated she was unsure if the "as needed" order was still in effect since the routine dosage order was provided by the physician according to the change he made at the 9-12-11 office visit with the resident. The "2010 Nursing Spectrum Drug Handbook," (page 489) indicated the maximum dosage of Flonase is 2 sprays in each nostril twice daily for a total of 200 mcg daily.</p> <p>In interview with Resident #18 on 10-5-11 at 9:30 a.m., she indicated her allergies were worsening and her doctor increased the Flonase to one spray in each nostril twice daily until there was a hard freeze. She did not indicate if she could use this medication in an "as needed" manner in addition to the routine dosing.</p> <p>2. Resident #12's clinical record was reviewed on 10-3-11 at 2:30 p.m. Her diagnoses included, but were not limited to, adult failure to thrive, progressive dementia and rheumatic heart disease. Resident #12 was admitted to the facility on 6-1-11 from an area extended care facility. Review of the record did not</p> |   |   |   |  |   |  |

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|   | <p>indicate the presence of physician orders to admit the resident to this facility or timely verification of the physician orders upon admission.</p> <p>In interview with the Nursing Supervisor on 10-4-11 at 11:16 a.m., she indicated with an initial admission, the facility will check the orders from the hospital or previous facility and then verify the orders by faxing or calling the physician. She indicated this information would then be noted in the resident's chart. In interview with the Nursing Supervisor on 10-4-11 at 1:42 p.m., she indicated she found a telephone order, dated 5-28-11, from the previous facility that said the resident was to be discharged to home with home health services. She indicated there was not an order for the resident to be discharged to this [assisted living] facility. She indicated she had conducted the admission for this resident, "and I should have made sure everything was done." She indicated, "I can't find anything that says the orders were verified by the doctor."</p> <p>The Nursing Supervisor provided a copy of a document on 10-4-11 at 1:31 p.m., of which she identified as Resident #12's admission orders. This document was entitled, "Physician's Orders," and had a typed date indicated as "1/2009." This</p> |   |   |   |  |   |  |

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|   | <p>document indicated a hand-written listing of Resident #12's medications. This document did not have a nurse verification date or signature and did not have a physician date or signature. This document had a total of 19 orders listed, with only 4 listed with dates which were on or after the date of admission. The orders with dates listed were dated for 8 ounces of Carnation Instant Breakfast 1 can daily by mouth with a start date of 6-1-11 and discontinuation date of 6-6-11; for 8 ounces of Carnation Instant Breakfast 1 can twice daily with a start date of 6-6-11 and a discontinuation date of 6-10-11; for 8 ounces of Carnation Instant Breakfast three times daily with a start date of 6-10-11 and for above the knee TED hose on both legs to be placed on in the mornings and removed each evening with a start date of 6-1-11. The first recapitulation orders for Resident #12 were indicated as "July 2011" and had a nurse verification signature dated 6-27-11 and a physician signature dated 7-27-11.</p> <p>Review of the nursing documentation did not indicate physician notification or verification of the resident's admission or medication orders. The first physician contact indicated in the clinical record was a fax sheet to and from the facility, dated 6-9-11, regarding her weight/dietary intake.</p> |   |   |   |  |   |  |

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| R0406   | <p>A policy entitled, "Admission Orders," with an effective date of 6-2-04, was provided by the Administrator on 10-4-11 at 8:55 a.m. This policy indicated, "Residents are admitted to the facility only by a physician's order which shall include: a. Admission Diagnosis b. Medical examination c. Orders for immediate care of the resident d. Orders for any and all medications..."</p> <p>(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview and record review, the facility failed to ensure universal precautions of handwashing and glove usage were used by a staff member while providing care to a resident requiring blood sugar testing and an insulin injection during the medication pass observation. This deficient practice affected 1 of 5 residents reviewed during a medication pass observation. (Resident #14)</p> <p>Findings include:</p> | R0406   | <p>1. On 10-13-11 the facility's policy and procedure regarding universal precautions was revised. An inservice was completed on 10-18-11 by the nursing supervisor under the direction of the Administrator. At the same inservice, handwashing requirements and techniques were also reviewed.2. All residents receiving care have the same potential to be affected. The corrective action of revising the universal precautions policy and procedure and the re-inservicing of the staff will ensure the safety of all residents.3. The systemic</p> | 10/25/2011  |  |   |  |

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|   | <p>LPN #1 was observed on 10-4-11 at 11:49 a.m. obtaining a blood sugar test on Resident #14, using the resident's glucometer machine. LPN #1 was not observed to be wearing gloves for this procedure or to wash her hands after performing the procedure. LPN #1 was observed immediately afterwards to administer 8 units of Novolog Insulin into Resident #14's left upper arm using a Flex-pen device. LPN #1 was not observed to wear gloves to administer the insulin. LPN #1 was not observed to wash her hands after this procedure.</p> <p>In interview with LPN #1 on 10-5-11 at 9:26 a.m., LPN #1 indicated, "No, I didn't wash my hands after I did [name of resident]'s insulin. No, I didn't wear gloves because I choose not to. Yes, I know it's in our universal precautions policy, but I just choose not to wear gloves. Don't know why, I just choose not to."</p> <p>A policy entitled, "Universal Precautions" with a revision date of 8-8-06 was provided by the Administrator on 10-5-11 at 8:25 a.m. This policy indicated, "It is the policy of this facility to adhere to universal precautions to provide a safe, sanitary and comfortable environment for the residents and staff. Precautions will be taken whenever there is known</p> |   | <p>changes of policy revision and inservicing will ensure that the deficiency does not recur.4. The Administrator and the nursing supervisor will visually check for correct hand washing techniques and the appropriate use of gloves by staff members during daily rounds five (5) to seven (7) days per week X three (3) months and then PRN. If a deficient practice is observed, appropriate disciplinary actions will be conducted.</p> |   |  |   |  |

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| R0414   | <p>infection, blood, or other body fluids. For the staff and resident interest, the staff will work to prevent the spread of infections to ourselves, co-workers and residents. Providing quality nursing care means that staff works to prevent nosocomial infections among our residents."</p> <p>A policy entitled, "Hand Cleaning" with an effective date of 7-12-00 was provided by the Administrator on 10-4-11 at 2:55 p.m. This policy indicated, "When to Wash Hands and Exposed Arms...Before and after any procedure...Before and after donning gloves...After touching bare human body parts other than clean hands and clean, exposed portions of arms...Before performing any invasive procedures..."</p> <p>(k) 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>Based on observation, interview and record review, the facility failed to ensure facility staff washed hands between care of residents during the medication pass observation. This deficient practice affected 1 of 5 residents reviewed during a medication pass observation. (Resident #14)</p> | R0414   | <p>1. On 10-13-11 the facility's policy and procedure regarding universal precautions was revised. An inservice was completed on 10-18-11 by the nursing supervisor under the direction of the Administrator. At the same inservice, handwashing requirements and techniques were also reviewed.2. All residents receiving care have the</p> | 10/25/2011  |  |   |  |

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|   | <p>Findings include:</p> <p>LPN #1 was observed on 10-4-11 at 11:43 a.m., to obtain Resident #6's glucometer from the medication room, hand the glucometer, a lancette and a glucometer test strip to the resident. The resident conducted the glucometer testing, and then handed the glucometer back to LPN #1. LPN #1 was then observed to return the glucometer to the medication room. Neither handwashing nor the use of a hand sanitizer was observed after this resident's care. While in the medication room, LPN #1 was observed to obtain Resident #14's glucometer and then take it to her room.</p> <p>LPN #1 was observed on 10-4-11 at 11:49 a.m., obtaining a blood sugar test on Resident #14, using the resident's glucometer machine. LPN #1 was not observed to be wearing gloves for this procedure or to wash her hands before or after performing the procedure. LPN #1 was observed immediately afterwards to administer 8 units of Novolog Insulin into Resident #14's left upper arm using a Flex-pen device. LPN #1 was not observed to wear gloves to administer the insulin. LPN #1 was not observed to wash her hands before or after this procedure.</p> |   | <p>same potential to be affected. The corrective action of revising the universal precautions policy and procedure and the re-inservicing of the staff will ensure the safety of all residents.3. The systemic changes of policy revision and inservicing will ensure that the deficiency does not recur.4. The Administrator and the nursing supervisor will visually check for correct hand washing techniques and the appropriate use of gloves by staff members during daily rounds five (5) to seven (7) days per week X three (3) months and then PRN. If a deficient practice is observed, appropriate disciplinary actions will be conducted.</p> |   |  |   |  |

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|   | <p>In interview with LPN #1 on 10-5-11 at 9:26 a.m., LPN #1 indicated, "No, I didn't wash my hands after I did [name of resident]'s insulin. No, I didn't wear gloves because I choose not to. Yes, I know it's in our universal precautions policy, but I just choose not to wear gloves. Don't know why, I just choose not to."</p> <p>A policy entitled, "Universal Precautions" with a revision date of 8-8-06 was provided by the Administrator on 10-5-11 at 8:25 a.m. This policy indicated, "It is the policy of this facility to adhere to universal precautions to provide a safe, sanitary and comfortable environment for the residents and staff. Precautions will be taken whenever there is known infection, blood, or other body fluids. For the staff and resident interest, the staff will work to prevent the spread of infections to ourselves, co-workers and residents. Providing quality nursing care means that staff works to prevent nosocomial infections among our residents."</p> <p>A policy entitled, "Hand Cleaning" with an effective date of 7-12-00 was provided by the Administrator on 10-4-11 at 2:55 p.m. This policy indicated, "When to Wash Hands and Exposed Arms...Before and after any procedure...Before and after</p> |   |   |   |  |   |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2011

FORM APPROVED

OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br>10/05/2011 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>PINE KNOLL ASSISTED LIVING CENTER |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>607 WILSON CREEK RD<br>LAWRENCEBURG, IN47025                           |                      |   |
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|   | donning gloves...After touching bare human body parts other than clean hands and clean, exposed portions of arms...Before performing any invasive procedures..." |   |   |                      |   |