

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: January 14, 15, 16, 17, 18, 22, and 23, 2013</p> <p>Facility number: 000315 Provider number: 155720 AIM number: 100289030</p> <p>Survey team: Terri Walters RN TC Martha Saull RN Dorothy Watts RN 1/14/13, 1/15/13, 1/16/13, 1/17/13, 1/23/13</p> <p>Census bed type: SNF/NF: 52 total: 52</p> <p>Census payor type: Medicare: 0 Medicaid:42 Other: 0 total: 52</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 29, 2013, by Jodi Meyer, RN</p>	F0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective February 22, 2013 to the state findings of the Recertification and State Licensure survey conducted on January 14, 15, 16, 17, 18, 22 and 23, 2013.</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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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a plan of care, to address alternative interventions to be attempted prior to the administration of a hypnotic, was in place for 1 of 10 residents reviewed for psychoactive medications. Resident #27</p> <p>Findings include: On 1/22/13 at 10 A.M., the clinical record of Resident #27 was reviewed. Diagnoses included, but were not limited to, the following: dementia,</p>	F0279	The corrective action taken for those residents found to be affected by the deficient practice is that the care plan of the resident identified as resident #27 has been reviewed and revised to include alternative interventions to be attempted and documented in the clinical record prior to the administration of a prn hypnotic. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide review was conducted to identify all residents who currently have a prn hypnotic medication orders. Each resident	02/22/2013	

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	<p>depressive disorder, generalized anxiety, psychosis, insomnia and Parkinson disease. The most recent MDS (minimum data set assessment) was dated 11/22/12 and indicated the resident had a total cognition score of 15. The score indicated the resident was alert and oriented. A care plan dated 5/23/12, indicated the resident "...has Parkinson...at times confused, potential for poor impulse control...delusional thoughts." The December 2012 MAR (medication administration record) was reviewed. The hypnotic medication, Ambien, was noted on the form for 5 mg at bedtime as needed for insomnia. The order was dated 7/19/11. The form indicated the resident had prn (as needed) Ambien administered 18 times during this month.</p> <p>On 1/23/13 at 11:55 A.M., the DON (Director of Nursing) and SSD (Social Service Director) were interviewed. The DON indicated documentation was lacking of a plan of care to address the diagnosis of insomnia and any alternative interventions that were to be attempted prior to the administration of Ambien. The DON indicated the staff attempt 2 - 3 interventions prior to giving the resident the Ambien but this information "isn't documented</p>		<p>identified with an order for prn hypnotics has had their care plan reviewed and revised to include alternative interventions which are to be attempted and documented in the clinical record prior to the administration of the prn hypnotic. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised their policy for Psychoactive Drug Monitoring. The policy now includes instructions on the documentation of alternative interventions in the clinical record prior to the administration of prn hypnotics. A mandatory in-service for all licensed nurses has been conducted on the revised policy on Psychoactive Drug Monitoring. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the administration/documentation of prn hypnotics. This tool will be completed by nursing administration weekly time four, then monthly times three and then quarterly times three. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</p>				

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	<p>anywhere." Nurses notes were reviewed for December 2012 and documentation was lacking for alternative interventions being attempted for 17 of the 18 administrations of Ambien. The January 2013 nurses notes were reviewed, documentation was lacking of alternative interventions attempted prior to Ambien being administered. The January 2013 MAR was also reviewed, at that time. Documentation was lacking on the form of any alternative interventions attempted prior to Ambien administration for the 6 times the medication was administered in January. The DON indicated at that time, if alternative interventions were attempted, they should be documented in the nurses notes or on the back of the MAR.</p> <p>On 1/23/13 at 1:20 P.M., the DON provided a current copy of the facility policy and procedure for "Policy for Psychoactive Drug Monitoring." The policy was dated 1/5/12. The DON was interviewed at the time and indicated the policy was lacking documentation of alternative interventions being attempted prior to prn (as needed) hypnotic medication administration. The DON indicated at</p>						

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	<p>that time, the staff should attempt alternative interventions to aid in sleep prior to prn administration of hypnotics.</p> <p>3.1-35(a)</p>			

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F0323 SS=E	<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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure the water temperatures in resident care areas were at a safe range in 7 of 15 bathrooms checked . This had the potential to affect 6 of 7 cognitively impaired and/ or independently ambulatory residents in the 7 affected resident bathrooms from a total census of 52. Resident room numbers:2, 4, 6, 9,12, 33, and 37.</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and assistance was provided for 1 of 4 residents reviewed for falls who met the criteria for falls. Resident # 39</p> <p>Findings include:</p> <p>A. On 1/15/13 at 2:00 P.M., the assistant housekeeper supervisor indicated the facility had turned down the mixing valve to lower hot water temperatures. On 1/15/13 at 2:10 P.M.,the assistant housekeeping</p>	F0323	<p>A. The corrective action taken for those residents found to be affected by the deficient practice is that upon investigation into the hot water temperature issue it was determined that there was a leak in the boiler holding tank. A new holding tank has been installed at the facility. Rooms 2, 4, 6, 9, 12, 33, 37 now have water temperatures that are in a safe range. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. A new holding tank has been installed at the facility which has corrected the water temperature issue. The measures or systemic changes that have been put in place to ensure the deficient practice does not recur is that the housekeeping staff have now been instructed to check water temperatures in resident care areas as part of their routine cleaning process Monday - Friday. The housekeeping staff has been instructed that water temperatures are to be maintained at 100 - 120 degrees</p>	02/22/2013	

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	<p>supervisor checked the following temperatures : room 2 was 125 degrees F. room 4 at 2:16 P.M., was 123.3 degrees F.</p> <p>On 1/15/13 at 2:52 P.M., during interview with assistant housekeeping supervisor she indicated a leak was found in the holding tank of the boiler last Thursday by the company who had installed the boiler in July 2012. She indicated the leak had been found when the company was checking the boiler for fluctuating water temperatures. She indicated a new holding tank was ordered and should be available in 7 to 10 days.</p> <p>On 1/15/13 at 3:30 P.M., Maintenance staff #1 and #2 checked the room 4's hot water temperature using their digital thermometers: room 4 at 3:40 P.M., Maintenance staff #1's thermometer reading was 123 degrees F and maintenance #2 staff was 123.7 degrees F.</p> <p>On 1/15/13 at 4:15 P.M., the administrator, housekeeping supervisor, and maintenance staff #1 and #2 were made aware of hot water safety concerns. At that time the housekeeping supervisor indicated the resident in room 4 with</p>		<p>F. They have been instructed through a mandatory in-service that they are to record the water temperatures and immediately report any unsafe water temperatures to the environmental services director. The environmental services director is then responsible for taking corrective action when an unsafe water temperature has been identified and document the corrective action taken on the temperature log. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is the maintenance department will continue to conduct their current random water temperature checks Monday through Friday as an additional layer of monitoring water temperature. Both the housekeepers' temperature logs and the maintenance water temperature logs will be reviewed monthly by the environmental services director and the findings reported at the facility Quality Assurance meeting. Based on review additional action will be taken as deemed necessary. B. The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #39 has had their fall risk care plan reviewed and revised to include additional interventions in an attempt to prevent future falls, which includes adequate staff</p>				

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	<p>the 123 F water temperature used a geri chair and was unable to transfer himself.</p> <p>On 1/15/13 at 4:15 P.M., the administrator, maintenance staff and housekeeping supervisor were interviewed regarding elevated water temperatures. The housekeeping supervisor indicated staff would be inserviced today, 1/15/13, on the use of hot and cold water mix and the need to monitor residents in regard to hot water temperatures. She indicated this information would be posted also.</p> <p>On 1/16/13 at 8:15 A.M., the housekeeping supervisor provided documentation of yearly 2012 and January 2013- Monday thru Friday- two random resident room water temperature checks done daily.</p> <p>On 1/16/13 at 3:30 P.M., the housekeeping supervisor provided water temperature checks of room 2, in a range below 120 F at 10 A.M., and 1:00 P.M. She indicated room 2 had a water temperature of 132 degrees F at 3:00 P.M., and had been 99.1 degrees F at 1:00 P.M.</p> <p>On 1/6/13 at 4:45 P.M., the Director</p>		<p>supervision and assistance. The corrective action taken for the other residents found to be affected by the same deficient practice is that a housewide review of all residents at high fall risk has been completed. Their care plans have been up-dated to include appropriate interventions in an attempt to prevent future falls, which include adequate supervision and assistance as warranted. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service for all nursing staff as it relates to providing adequate supervision and assistance to those residents at high fall risk. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to review residents at high fall risk. The tool will monitor to determine if all safety interventions were in place in accordance with the plan of care to include adequate supervision and assistance as warranted. This tool will be completed by nursing administration weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</p>				

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	<p>of Nursing (DON), provided a list of residents in the facility who were alert and oriented and independent in transfer. She indicated these residents had been educated on using a hot and cold water mix. Residents who independently transferred and were not alert and oriented had their sink water turned off by maintenance staff. She indicated the facility would do random one hour water temperature checks on alert and oriented and independent resident's water.</p> <p>On 1/18/13 at 3:30 P.M., facility provided water temperature documentation for 1/17/13. An elevated hot water temperature had been in room 6 of 123.8 degrees F.</p> <p>On 1/18/13 at 9:55 A.M., the housekeeping supervisor provided documentation of a water temperature on 1/18/13 at 4:00 A.M., -5:00 A.M., room 6 had been 125.4 degrees F. On 1/18/13 at 6:00-7:00 A.M., room 9 had been 122.9 degrees F</p> <p>On 1/22/13 at 3:10 P.M., during interview with the housekeeping supervisor she indicated the facility had the mixing valve changed out on</p>			

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	<p>Friday 1/18/13. The facility had a holding tank installed on 1/21/13. The following water temperatures were documented :</p> <p>1/22/13 at 10-11:00 A.M., room 9 was 135.9 degrees F. 1/22/13 at 11:00 A.M.,-12:00 P.M. room 33 was 137.5 degrees F 1/22/13 at 11:00 A.M.,-12:00 P.M., room 37 was 140 degrees F 1/22/13 at 11:00 A.M.,-12:00 P.M. room 12 was 123.1 degrees F</p> <p>On 1/23/13 at 2:30 P.M. during interview with the housekeeping supervisor, she indicated at 8:00 A.M., today the water was turned off and a check valve was changed. The following water temperatures were documented: 1/23/13 at 11:00 A.M., -12:00 P.M., room 33 was 122.1 F 1/23/13 at 11:00 A.M., -12:00 P.M., room 37 was 125.4 degrees F 1/23/13 at 11:00 A.M.,-12:00 P.M., room 12 was 124.9 degrees F</p> <p>On 1/15/13 at 1:30 P.M., during interview with assistant housekeeper supervisor, she indicated if water temperatures were too high or too low, the maintenance staff after checking in am, would then turn the</p>						

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	<p>mixing valve up or down to adjust the water temperature to the safe water temperature range.</p> <p>On 1/15/13 at 1:35 P.M., during interview with Maintenance staff member #1, he indicated he wanted the water temperature for the resident areas to range from 114 degrees F to 120 degrees F. He indicated the facility had one boiler. He indicated he checked water temperatures at the facility between 7:10 A.M., to 7:15 A.M. He indicated the facility had a new boiler installed in July 2012. He indicated there had been a continued problem with this new boiler system .</p> <p>On 1/23/13 at 2:30 P.M., during interview, the housekeeping supervisor indicated the facility did not have a policy regarding maintaining water temperatures in the facility. She indicated she had developed a policy today (1/23/13) to assure water temperatures were maintained in a range of 110-120 degrees F. She indicated the policy still had to be approved by the administrator of the facility.</p> <p>B.1. On 1/17/13 at 1:08 P.M., Resident #39 was observed sitting in</p>				

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	<p>the lounge by the 2nd floor nurses station. He was sitting in a recliner chair that was not reclined and had a personal/clip alarm attached to his shirt.</p> <p>On 1/18/13 at 12:00 P.M., record review indicated diagnoses which included but were not limited to: IDDM, legally blind, OCD (obsessive compulsive disorder) personality, insomnia, unsteady gait, major depression recurrent with psychotic features, agitation/generalized anxiety, and recurrent urinary tract infections.</p> <p>On 1/18/13 at 12:45 P.M., Resident #39's care plan (onset 10/29/12) which addressed at risk for falls r/t (related to) blindness was reviewed. Interventions included but were not limited to: "keep area free of clutter, personal/clip alarm discontinued on 11/29/12 and voice alert alarm (verbal recording telling resident to sit down) added and then discontinued back to personal alarm on 12/27/12, may leave gait belt on during waking hours, resident to be gotten up on day shift list, place in recliner after meals, bed in low position, resident to be in line of sight when up in recliner or w/c -10/29/12, bilateral floor mats to bed 12/15/12, bed alarm (pad) under</p>			

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	<p>shoulders while abed-12/25/12, and 1/9/13- if resident agitated offer snack, walking, or activity."</p> <p>On 1/23/13 at 9:55 A.M., reviewed restorative fall documentation with the restorative nurse and the Director of Nursing (DON). Documentation indicated a fall had occurred on 10/10/12 at 6:15 A.M. The resident had been up in the lounge by the nurses station with a personal/clip alarm intact when the fall had occurred. The restorative nurse indicated his alarm had sounded. She indicated the resident would be assisted up later in the day by the day shift.</p> <p>Another fall occurred on 10/21/12 at 4 :45 A.M. Documentation indicated the resident had been in the lounge by the nurses station in a recliner with a personal alarm attached. The restorative nurse indicated the alarm had sounded. The new intervention was to keep the resident in sight when up in recliner or wheelchair.</p> <p>A fall also occurred on 11/29/12 at 4:30 P.M. The resident again was in the lounge by the nurses station with a personal alarm intact. The restorative nurse indicated the alarm had sounded and a nurse had been</p>			

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	<p>present but unable to reach the resident. New intervention was to use a voice alert alarm that verbalized to the resident to wait for assistance. The restorative nurse indicated the voice alert alarm had worked for approximately a month and then had to be discontinued. She indicated Resident #39 continued to use a personal alarm when up in chair.</p> <p>A fall occurred on 12/15/12 at 12:10 A.M., Resident #39 had been in bed with a personal alarm attached. The restorative nurse indicated the alarm had sounded. The new intervention was to place bilateral floor mats around the bed.</p> <p>A fall occurred on 12/25/12 at 1:30 A.M. The restorative fall documentation indicated the resident climbed out of bed onto floor mat. The personal alarm was on and working, but the alarm was pulled off the bed . The personal alarm had not sounded. The resident had an injury of a scratch to his cheek. The restorative nurse indicated the new intervention was to use a pad alarm under the resident's shoulder in bed.</p> <p>A fall occurred on 1/9/13 at 1:30</p>				

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	<p>P.M. The resident had been sitting in a recliner at the lounge by the nurses station. The restorative nurse indicated the alarm sounded and staff had been present but unable to reach the resident. The new intervention was to offer snacks, activities, and walking activity.</p> <p>On 1/23/13 at 10:22 A.M., the DON and the restorative nurse were made aware of the problem with the lack of staff supervision and assistance needed to prevent falls. They indicated the resident was receiving physical therapy at present to improve ambulation.</p> <p>3.1-19(a) 3.1-19(r) 3.1-45(a)(2)</p>				

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 alternative interventions were attempted prior to the administration of a hypnotic for 1 of 10 residents reviewed for psychoactive medications. Resident #27</p> <p>Findings include:</p> <p>On 1/22/13 at 10 A.M., the clinical record of Resident #27 was reviewed.</p>	F0329	The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #27 now has documentation in the clinical record of what alternative interventions that were attempted prior to the administration of a prn hypnotic. As far as the consultant Pharmacist's documentation related to a different dosage this was an error in documentation and has been addressed with the Pharmacist. The corrective action taken for the other residents	02/22/2013			

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	<p>Diagnoses included, but were not limited to, the following: dementia, depressive disorder, generalized anxiety, psychosis, insomnia and Parkinson disease. The most recent MDS (minimum data set assessment) was dated 11/22/12 and indicated the resident had a total cognition score of 15. The score indicated the resident was alert and oriented.</p> <p>A care plan dated 5/23/12, indicated the resident "...has Parkinson...at times confused, potential for poor impulse control...delusional thoughts."</p> <p>The December 2012 MAR (medication administration record) was reviewed. The hypnotic medication, Ambien, was noted on the form for 5 mg at bedtime as needed for insomnia. The order was dated 7/19/11.</p> <p>The form indicated the resident had prn Ambien administered 18 times during that month. The January 2013 MAR was also reviewed at the time. The form indicated the resident was given prn (as needed) Ambien a total of 6 times during the month. Documentation was lacking of alternative interventions being attempted prior to administration of Ambien.</p> <p>On 1/23/12 at 11:55 A.M., the DON</p>		<p>having the potential to be affected by the same deficient practice is that a housewide audit has been completed on all residents on a prn hypnotic. There is now documentation of alternative interventions on the clinical record which have been attempted prior to the administration of each prn hypnotic. The measures or systemic changes that have been put into place to ensure that the deficient practice does recur is that the facility has reviewed and revised their policy for Psychoactive Drug Monitoring. The policy now includes instructions on the documentation of alternative interventions in the clinical record prior to the administration of prn hypnotics. A mandatory in-service for all licensed nurses has been conducted on the revised policy on Psychoactive Drug Monitoring. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the administration/documentation of prn hypnotics. This tool will be completed by nursing administration weekly times four weeks, then monthly times three months and then quarterly times three quarters.</p>				

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	(Director of Nursing) and SSD (Social Service Director) were interviewed. The DON indicated documentation was lacking of a plan of care to address the diagnosis of insomnia and any alternative interventions that were to be attempted prior to the administration of Ambien. The DON indicated the staff attempt 2 - 3 interventions prior to giving the resident the Ambien but this information "isn't documented anywhere." For 17 of the 18 times the resident was administered Ambien in December 2012, documentation was lacking of the resident having had alternative interventions attempted and there was not care plan to address insomnia. At the time, the January 2013 MAR was also reviewed. Documentation was lacking on the form of any alternative interventions attempted prior to Ambien administration for the 6 times the medication was administered in January. Nurses notes were also reviewed for December 2012 and documentation was lacking for alternative interventions being attempted for 17 of the 18 administrations of Ambien. January 2013 nurses notes were reviewed also at the time, with documentation lacking of alternative interventions			

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	<p>attempted prior to Ambien being administered. The DON indicated at the time, if alternative interventions were attempted, they should be documented in the nurses notes or on the back of the MAR.</p> <p>On 1/23/13 at 1:20 P.M., the DON provided a current copy of the facility policy and procedure for "Policy for Psychoactive Drug Monitoring." This policy was dated 1/5/12. The DON was interviewed at this time and indicated the policy was lacking documentation of alternative interventions being attempted prior to prn (as needed) hypnotic medication administration. The DON indicated at this time, that staff should attempt alternative interventions to aid in sleep prior to prn administration of hypnotics.</p> <p>On 1/23/13 at 2:20 P.M., the DON was again interviewed. She provided copies of the following forms: Consultant Pharmacist Communication to Physician dated 11/26/12 which indicated the following: "Resident receives Ambien 10 mg... q (every) hs (bedtime) prn (as needed) sleep...Please consider d/c (discontinue) Ambien 10 mg and start Ambien 5 mg po q hs prn sleep...Please consider changing to</p>			

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	<p>Lunesta..."</p> <p>The October 2012 MAR indicated the following: "Ambien 5 mg at hs prn.." This order had an origination date of 7/19/11.</p> <p>The MAR (10/2012) was signed by the Pharmacist as reviewed on 11/20/12. The December 2012 MAR indicated the following: "Ambien 5 mg at hs prn..." The MAR was signed by the Pharmacist as reviewed on 1/22/13.</p> <p>The DON was unable to verify the pharmacist consultant comment of the resident receiving Ambien 10 mg, as noted on the 11/26/12 pharmacy consult.</p> <p>The DON indicated after she reviewed the above MARs, dated October 2012 and December 2012, the resident remained on Ambien 5mg prn. The DON was unable to clarify and/or verify the consultant pharmacist's comment of the resident being on Ambien 10mg in her 11/26/12 note. The DON indicated it appeared as the resident remained on 5mg of Ambien.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>						

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F0465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure bathroom floors were clean for 4 of 37 resident bathrooms observed. Rooms: 23, 26, 27, and 28</p> <p>Findings included:</p> <p>1. On 1/14/13 at 3:49 P.M., the bathroom floor of room 28 had brown soiling and/or staining around one side and the back side of the base of the commode. The bathroom floor had soil beneath the wax on the floor.</p> <p>On 1/15/13 at 9:36 A.M., the bathroom floor of room 27, had brown soil and / or staining at the base of the commode. The bathroom floor had a wax build up with black soil.</p> <p>On 1/15/13 at 2:57 P.M., the bathroom floor of room 26, had a rectangular rust stain in front and back of the flooring at the base of the commode. The bathroom floor had a wax build up with soil noted.</p> <p>On 1/15/13 at 3:05 P.M., the</p>	F0465	<p>The corrective action taken for those residents found to be affected by the deficient practice is that the bathroom identified as room 28 has had the bathroom floor replaced. The corrective action taken for those residents found to be affected by the deficient practice is that the bathroom identified as room 27 has had the bathroom floor replaced. The corrective action taken for those residents found to be affected by the deficient practice is that the bathroom identified as room 26 has had the bathroom floor replaced. The corrective action taken for those residents found to be affected by the deficient practice is that the bathroom identified as room 23 has had the bathroom floor replaced. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit was conducted of all resident bathrooms. The facility has developed a schedule to replace three residents' bathroom floors each month until all resident bathroom floors have been replaced. The facility has also hired a "floor tech" that will be providing appropriate floor care</p>	02/22/2013			

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	<p>bathroom floor of room 23, had brown soil throughout the floor.</p> <p>On 1/23/13 at 1:30 P.M., the above resident bathrooms were toured with the housekeeping supervisor. She indicated the floors were soiled and a build up of wax and/ or staining and soil was noted at the base of the commodes. She indicated the facility was lacking of a staff member to do specific floor care, "a floor guy." She indicated she and the assistant housekeeping supervisor and other housekeeping staff were cleaning what they could. .</p> <p>3.1-19(f)</p>		<p>throughout the facility on a routine schedule. The measures or systematic changes that have been put into place to ensur the deficient practice does not recur is that a mandatory in-service was conducted for all housekeepers. The housekeepers were instructed on reporting any soiled bathroom floors that could not be satisfactorily cleaned during routine cleaning to the environmental services director. The identified bathroom floors will be assigned to the floor tech for appropriate cleaning interventions which may include stripping and re-waxing of the identified floor. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the condition of resident bathroom floors. This tool will be completed by environmental services director weekly times four weeks, the monthly times three months and then quarterly times three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>		