

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2012
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 27, 28, 29, March 1, 2, 5, 6, 7, 2012</p> <p>Facility number: 000439 Provider number: 155716 AIM number: 100275070</p> <p>Survey Team: Diane Hancock, RN TC Barb Fowler, RN Vickie Ellis, RN Amy Wininger, RN 2/27, 2/28, 2/29, 3/1, 3/5, 3/6, 3/7, 2012</p> <p>Census bed type: SNF 28 NF 52 SNF/NF 109 Residential 8 Total 197</p> <p>Census payor type: Medicare 20 Medicaid 129 Other 48 Total 197</p> <p>Sample: 29 Residential sample: 6</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 April 6, 2012 to the state findings of the Recertification and State Licensure Survey conducted on February 27 th through March 7 th , 2012.</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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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/09/12 by Suzanne Williams, RN</p>			
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F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents reviewed with self-releasing seat belts, in the total sample of 29, was free of physical restraint, in that the resident could not release the seat belt. (Resident #149)</p> <p>Finding includes:</p> <p>The clinical record for Resident #149 was reviewed on 2/29/12 at 9:45 A.M. The care plan, dated 10/15/10, indicated that Resident #149 was a high risk for falls. The intervention for the resident included a self-releasing seatbelt.</p> <p>The "Physical Restraint Reduction Assessment" for 3/8/11, 6/16/11, 9/30/11, and 1/13/12, indicated Resident #149 was a "poor candidate" for a restraint reduction. On 3/8/11, 6/16/11, 9/30/11, and 1/13/12, the documentation indicated Resident #149 was able to release the self-releasing seatbelt upon command.</p> <p>During observation on 2/29/12 at 10:00 A.M., Resident #149 was noted to be</p>	F0221	<p>The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 149 has been reassessed related to the use of a restraint. Based on the assessment results, the seat belt was discontinued; therefore, the resident is no longer restrained.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same alleged deficient practice is that all residents utilizing a self-releasing, alarmed seat belt device on their wheel chairs have been reassessed. Based on these assessments, any resident who was unable to release the seat belt upon command has medical justification for the use of the device, and the device is being monitored in accordance with facility policy. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has conducted a mandatory in-service for all licensed nurses on the facility restraint policy and procedure. The corrective action taken to monitor to assure performance to assure</i></p>	04/06/2012			

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	<p>sitting in his wheelchair with the self-releasing seatbelt loosely around his waist. Resident #149 was asked to release his self-releasing seatbelt. After asking Resident #149 four times to release his seatbelt, Resident #149 was shown his seatbelt, to which he replied he didn't know what it was.</p> <p>Upon interview of LPN # 2 on 2/29/12 at 2:40 P.M., LPN # 2 indicated Resident #149 was able to release his self-releasing seatbelt. LPN #2 indicated the seatbelt was used for positioning of the resident and because the resident was at risk for falls. When LPN #2 was queried regarding the seatbelt being too loose to assist with positioning or fall risk, LPN #2 indicated Resident #149 had been evaluated by O.T. [Occupational Therapy] in 12/11, for the self-releasing seatbelt. LPN #2 spoke with the O.T. Department and was told the resident was not evaluated for the self-releasing seatbelt but was evaluated for a chair cushion for positioning. LPN #2 then stated she would speak with the physician to obtain an order for an O.T. evaluation for Resident #149 to possibly discontinue the self-releasing seatbelt.</p> <p>On 3/1/12 at 9:10 A.M., LPN # 2 indicated she had asked Resident #149 to release his self-releasing seatbelt 3 times</p>		<p><i>compliance through quality assurance</i> is a Quality Assurance Tool has been developed and implemented to ensure that the facility restraint policy and procedure are being followed. This tool will be completed by the Director of Nursing and/or her designee 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 quarterly Quality Assurance meeting to determine if any additional interventions are warranted.</p>				

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	and the resident was unable to release it. LPN #2 indicated O.T. was going to evaluate Resident #149 for the seatbelt. 3.1-3(w) 3.1-26(o)			

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F0223 SS=A	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for allegations of abuse, in the sample of 29, was free of abuse, in that the facility investigation indicated Resident #51 experienced physical abuse from a staff member.</p> <p>Findings include:</p> <p>On 3/01/12 at 4:00 p.m., the DoN [Director of Nursing] provided a facility investigation of staff to resident abuse involving Resident #51. During an interview at that time, the DoN indicated the abuse had been substantiated.</p> <p>A Final Report, dated 05/16/11, indicated an incident occurred on 05/14/11 when staff was trimming the fingernails of Resident #51. The report further indicated "[Name of LPN #1] asked two CNAs [CNA #1 and CNA #2] to accompany her to protect the resident and make sure that resident stayed safe during</p>	F0223	<p>The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 51 does not appear to have experienced any negative psychosocial effects from the event that occurred. The bruises on the wrist and back of the hand are resolved. As the facility investigation revealed, those individuals responsible were suspended at the time the event occurred and later terminated upon completion of the investigation. <i>The corrective action taken for the other residents having the potential to be affected by the same alleged deficient practice is that all residents have the potential to be affected by the alleged deficient practice. There have been no other reported incidents of allegations of abuse. The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur is that the facility has reviewed its policy and procedure on abuse. The facility</i></p>	04/06/2012			

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	<p>the trimming...During the procedure, the resident stated, 'Don't do that' but nurse continued....during the process, resident stated, 'Don't do that' several times. Nurse did not stop and instructed the CNAs to continue in order to finish the trimming...at or about 5 hours later, bruising and redness was identified on the wrist and back of the hand..."</p> <p>The facility investigation indicated the abuse policy was followed, the immediate notifications were complete, the three staff members were immediately suspended pending investigation, and at the completion of the investigation, the staff members were terminated.</p> <p>The Abuse Prohibition Policy and Procedure, provided by the Administrator on 03/06/12 at 10:15 A.M., indicated, "Policy...It is the policy of Good Samaritan Home Inc to prevent abuse..."</p> <p>3.1-27(a)(1)</p>		<p>has conducted a mandatory in-service for all staff on the facility abuse policy. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance Tool</i> has been developed and implemented to monitor for compliance. The tool includes interviews of residents and staff to ensure that the facility abuse policy is being followed. This tool will be completed by the Social Service Director and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes of the tool will be reviewed at the quarterly Quality Assurance meeting to determine if additional interventions are warranted.</p>		

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F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to provide services in accordance with each resident's orders and plans of care, for 7 of 29 residents reviewed for following care plans and physician's orders, in the sample of 29, in that oxygen was not provided as ordered, pain was not followed up on, medications were not transcribed as ordered, straws were given when ordered not to be used, and alarms were not used as ordered and care planned. (Residents #182, #179, #125, #155, #37, #82, #94)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #182 was reviewed on 2/28/12 at 9:30 A.M. Resident # 182 was admitted to the facility with a diagnosis including, but not limited to, fractured right femur from a fall at home.</p> <p>On 1/31/12, Resident #182 received a physician's order for Beneprotein [protein supplement] 1 scoop in 6 ounces of plain yogurt 2 times a day. The order was</p>	F0282	<p>The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 182 has had his physician's orders and plan of care reviewed. All orders have been transcribed accurately, and the resident is receiving services in accordance with those physician's orders and plan of care. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 179 is no longer a resident at this facility. The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as Resident # 125 is receiving oxygen therapy and is wearing gripper socks in accordance with the current physician's orders. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified on the 2567 as Resident # 155 was actually Resident # 151. Resident # 151 is receiving all fluids in accordance with the current physician's orders, including no</p>	04/06/2012			

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	<p>incorrectly transcribed as Benefiber onto the resident's collective orders and the MAR [Medication Administration Record]. The collective orders were signed on 1/31/2012 by Resident #182's physician. According to the MAR, Resident #182 received Benefiber 1 scoop in 6 ounces plain yogurt 2 times a day from 2/1/12 through 2/27/12. On 3/1/12 at 2:10 P.M., an order was received to "discontinue Benefiber due to no longer being on the market."</p> <p>Upon interview of LPN #4 on 3/6/2012 at 9:00 A.M., LPN #4 indicated Resident #182's order was transcribed wrong. LPN #4 also indicated she did not know if Resident #182 received Beneprotein or Benefiber from 2/1/12 through 2/27/12.</p> <p>Upon query of the DoN [Director of Nursing] on 3/6/12 at 10:50 A.M., the DoN indicated Resident #182's order was incorrectly transcribed and Resident #182 did not have an order to discontinue the Beneprotein.</p> <p>During the record review, the following was also noted: An order was received on 12/28/11 from the hospital for a knee immobilizer for 2 weeks only.</p> <p>On observation of Resident #182 on</p>		<p>straws. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 37 has her safety alarms in place and functioning properly in accordance with her plan of care. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 82 is no longer a resident at this facility. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 94 has been reassessed related to her safety needs. The safety alarms have been discontinued. The resident has had no falls since her safety needs were reassessed. <i>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 alleged deficient practice. The facility has implemented a practice whereby the Unit Managers review all orders for newly admitted residents to ensure the admission orders have been transcribed accurately. The nurses have been directed to monitor all immobilizers, splints, gripper socks, safety alarms etc. each shift to ensure they are being utilized in accordance with</i></p>				

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	<p>2/28/12 at 8:10 A.M., Resident #182 had a knee immobilizer on his right leg while he was sitting in his wheelchair.</p> <p>On observation of Resident #182 on 2/28/12 at 10:30 A.M., Resident #182 was lying in his bed with the knee immobilizer on his right leg.</p> <p>On observation of Resident #182 on 2/28/12 at 2: 40 P.M., Resident #182 was lying in his bed with the knee immobilizer on his right leg.</p> <p>On observation of Resident #182 on 2/29/12 at 1015 A.M., Resident #182 was sitting in his wheelchair with the right knee immobilizer on.</p> <p>On observation of Resident #182 on 2/29/12 at 2:20 P.M., Resident #182 was observed with the right knee immobilizer on.</p> <p>On 3/1/12 at 12:50 P.M., an order was received for Resident #182 to wear the knee immobilizer at night only.</p> <p>On query of the DoN on 3/6/12 at 10:50 a.m., the DoN indicated Resident #182 had been sent to the hospital and had returned with his knee immobilizer on, but no order was received for the knee immobilizer to be continued. The order from P.T. [physical therapy] indicated Resident #182 was to wear the knee immobilizer on the left knee.</p>		<p>the physician's orders and/or plan of care. The facility has implemented a practice whereby the off-going and on-coming nurses review the MARs together at each change of shift to ensure that all pain scales and any non-medication interventions have been documented. A house wide audit has been conducted on all residents receiving oxygen therapy to ensure they are receiving oxygen therapy in accordance with their current physician's orders. A house wide review of all residents with orders for no straws has been completed. This list will be maintained and up-dated by the dietary manager. The list has been made readily available to all nursing staff so that no straw orders can consistently be followed. The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur is that a mandatory nursing in-service will be conducted for all nursing staff. The following topics will be reviewed: accurate transcription of physician orders, following plan of care as it relates to immobilizers, splints, gripper socks, safety alarms and other care plan interventions, oxygen usage, and swallowing precautions, such as no straw orders. The nurses have been in-serviced on the new practice implemented related to reviewing</p>				

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	<p>2. The clinical record of Resident #179 was reviewed on 2/28/12 at 8:45 A.M. Resident #179's plan of care, dated 1/2/12, indicated that her pain was to be evaluated on a scale of 1-10, 1 hour after pain med/intervention and Resident #179 was to have non-medication interventions for pain relief. Resident #179 also had a physician's order, dated 12/20/11, to score pain on a 1-10 scale when given med and with follow-up pain - pain scale and relief score.</p> <p>Review of the Medication Administration Record included, but was not limited to, the following: On 1/1/12 at 8:45 A.M., 2:00 P.M., 7:00 P.M., Resident #179 received Norco [pain medication] for pain with no relief scale assessment completed according to the physician's order and as per the plan of care nor were any alternative interventions done. On 1/2/12 at 9:10 P.M., Resident #179 received Norco with no follow-up pain scale assessment. On 1/3/12 at 5:30 A.M., Resident #179 received Norco with no follow-up pain scale assessment. On 1/4/12 at 12:15 A.M., 7:30 A.M., and 12:15 P.M., Resident #179 received Norco with no follow-up pain scale assessment. On 1/7/12 at 5:45 A.M., Resident #179</p>		<p>the MARs at each change of shift for pain scale and non-medication intervention documentation. The in-service will reinforce the overall importance of providing care and service for each resident in accordance with their physician's orders and their individualized plan of care. <i>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 compliance. This tool includes monitoring of the following: accuracy of transcribed physician's orders, proper application of immobilizers/splints/braces in accordance with physician's orders, documentation of pain scales and alternative non-medication interventions, oxygen usage in accordance with physician's orders, application of safety devices such as gripper socks and safety alarms in accordance with physician's orders and the resident's plan of care and the following of swallowing precaution instructions, such as no straws. This tool will be completed by the Director of Nursing and/or her designee 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 quarterly Quality Assurance</i></p>				

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	<p>received Norco with no follow-up pain scale assessment.</p> <p>On 1/8/12 at 12:45 A.M., Resident #179 received Tylenol [pain medication] with no follow-up pain scale assessment.</p> <p>On 1/8/12 at 7:15 P.M., Resident #179 received Norco with no follow-up pain scale assessment.</p> <p>On 1/9/12 at 12:15 A.M. and 7:05 P.M., Resident #179 received Norco with no follow-up pain scale assessment.</p> <p>On 1/10/12 at 8:30 A.M., Resident #179 received Norco with no follow-up pain scale assessment.</p> <p>On 1/11/12 at 1:00 P.M., Resident #179 received Lortab [pain medication] with no non-medication interventions or follow-up pain scale assessment.</p> <p>On 1/14/12 at 7:30 P.M., Resident #179 received Norco with no follow-up pain scale assessment.</p> <p>On 1/15/12 at 10:00 P.M., Resident #179 received Norco with no follow-up pain scale assessment.</p> <p>On 1/16/12 at 11:00 P.M. Resident #179 received Norco with no non-medication interventions or follow-up pain scale assessment.</p> <p>On 1/18/12 at 8:00 A.M., Resident #179 received Norco with no follow-up pain scale assessment.</p> <p>On 1/21/12 at 8:45 P.M., Resident #179 received Norco with no follow-up pain scale assessment.</p>		meeting to determine if additional interventions are warranted.				

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	<p>On 1/22/12 at 8:10 P.M., Resident #179 received Norco with no follow-up pain scale assessment.</p> <p>Interview with LPN #2 on 2/28/12 at 2:00 p.m. indicated follow-up should be charted on the pain flow sheet.</p> <p>3.a. Resident #125 was observed on 2/28/12 at 8:45 a.m., wearing a nasal cannula with oxygen flowing through it at 3 liters [L] per minute.</p> <p>On 2/28/12 at 1:55 p.m., Resident #125 was observed lying in his bed with his eyes closed. A nasal cannula was delivering oxygen at 2.5 L per minute.</p> <p>On 2/29/12 at 9:05 a.m., Resident #125 was observed lying in bed on his left side with a nasal cannula delivering oxygen at a rate of 2.5 L per minute.</p> <p>Record review on 2/28/12 at 11:15 a.m. indicated Resident #125 had a diagnosis of Chronic Obstructive Pulmonary Disease [COPD].</p> <p>A review of the doctor's orders indicated Resident #125 had a doctor's order, dated 2/2/12, to discontinue Oxygen as needed order, and to continue use of Oxygen continuously at 2 L per minute via nasal cannula.</p>			

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	<p>b. On 2/28/12 at 1:55 p.m., an observation was made of Resident #125 lying in bed with his eyes closed and without gripper socks on his feet.</p> <p>On 2/29/12 at 2:45 p.m., an observation was made of Resident #125 lying in bed on his left side with no gripper socks to his feet.</p> <p>A record review of the doctor's orders, dated 2/27/12, indicated Resident #125 had a doctor's order for gripper socks on at all times when not wearing shoes.</p> <p>Resident #125's care plan, dated 2/27/12, indicated Resident #125 had a care plan to wear gripper socks at all times unless his shoes were on.</p> <p>4. On 3/5/12 at 5:55 p.m., Resident #155's tray was being delivered to the resident. The tray included a pureed diet and drinks with two straws.</p> <p>On 3/6/12 at 8:45 a.m. a straw was observed in Resident #155's bedside water cup.</p> <p>On 3/6/12 at 8:59 a.m. Resident #155's meal ticket indicated no straws.</p> <p>A review of Resident #155's record on 2/28/12 at 10:00 a.m., indicated Resident</p>			

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	<p>#155 had a diagnosis of dysphasia.</p> <p>A record review of the physician's order sheet, dated 2/10/12, indicated Resident #155 had an order for a puree diet with thin liquids and no straws.</p> <p>A review of the care plan for potential for swallowing complications, dated 1/4/12, indicated no straws were to be used.</p> <p>A review of Resident #155's swallowing guide, dated 4/22/09, indicated Resident #155 was to have a mechanical soft diet with thin liquids and no straws.</p> <p>During an interview on 3/6/12 at 8:55 a.m., LPN #2 indicated Resident #155 was not to have straws.</p> <p>5. The clinical record of Resident #37 was reviewed on 02/28/12 at 1:30 P.M. The record indicated the diagnoses included, but were not limited to, dementia and osteoporosis.</p> <p>During the initial tour on 02/27/12 at 11:15 A.M., the Unit Manager #1 indicated Resident #37 had experienced falls and was cognitively impaired. Resident #37 was observed at that time, lying in bed.</p> <p>A Fall Risk Assessment, dated 11/21/11, indicated Resident #37 was at a high risk</p>						

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	<p>to fall.</p> <p>A Care Plan, dated 01/16/12, indicated a problem of Fall risk with interventions that included, but were not limited to, "self releasing alarming seat belt while up in wheelchair."</p> <p>A Nurse's Note dated 02/02/12 at 1515 [3:15 P.M.], indicated, "Resident found lying on stomach on floor with face noted to be on floor. Small red area noted on center of forehead near hairline."</p> <p>An Interdisciplinary Fall Committee note dated 02/03/12, indicated Resident #37 experienced a fall from her wheelchair on 02/02/12. The note further indicated, "Staff found self releasing seat belt alarm turned off...Intervention: Make sure alarms in place are on and sounding..."</p> <p>In an interview with QA [Quality Assurance] nurse on 03/06/12 at 10:20 A.M., she indicated the alarms were not turned on at the time of the 02/02/12 fall.</p> <p>In an interview with the DoN [Director of Nursing] on 03/06/12 at 11:30 A.M., she indicated, "...They are supposed to check the alarms for function every shift."</p> <p>6. During the initial tour, on 2/27/12 at</p>						

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	<p>11:47 a.m., LPN #3 indicated Resident #82 was not supposed to transfer by herself. She indicated they were using pressure alarms to alert staff if she got up, but indicated during interview at that time, "she takes it off."</p> <p>On 2/29/12 at 11:08 a.m., Resident #82 was observed getting up from her bed to the bedside commode. No alarm sounded. While the resident was seated on the bedside commode, CNA #3 entered the room. She clipped the call light to the resident's pants, left the resident on the bedside commode, washed her hands, and left the room.</p> <p>The resident used the bedside commode, pushed the call light at 11:12 a.m., and immediately stood up and began attempting to pull up her pants and incontinence brief. She sat down when she was unable to pull up everything. CNA #3 answered the call light at 11:14 a.m. and proceeded to assist the resident.</p> <p>Resident #82's clinical record was reviewed on 2/28/12 at 11:02 a.m. The resident's diagnoses included, but were not limited to, dementia, hypertension, osteopenia, and severe degenerative disc disease. The resident had a Fall Risk Assessment, dated 2/1/12, indicated Resident #82 was at risk for experiencing</p>						

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	<p>a fall. The care plan, dated 2/14/12, for fall risk, included, but was not limited to, the following:</p> <ul style="list-style-type: none"> -remind resident to use call light when needing assistance -up with assist of 1 -notify MD [medical doctor] and responsible party, and implement interventions should a fall occur -bed sensor in bed -chair sensor in w/c [wheelchair] <p>Nurses' notes included, but were not limited to, the following:</p> <p>2/21/12 0100 [1:00 a.m.] "Resident up to BSC [bedside commode] [with] assist of 1..."</p> <p>2/21/12 2155 [9:55 p.m.] "...Resident continues to transfer self setting alarms off several times per shift, will on occasion use call light when reminded per staff, transfers [with] assist of 1."</p> <p>2/28/12 1100 [11:00 a.m.] "Resident has been non compliant numerous times alarms sounding transferring self [without] assist from BSC to W/C [wheelchair] to bed. Assigned 1:1 care for resident R/T [related to] unsafe transfers."</p> <p>2/28/12 1315 [1:15 p.m.] "Resident alert [with] confusion. continuing to get up unassisted to utilize bedside commode. Resident having frequency [with] urination...Alarm audible et functioning.</p>			

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	<p>Instructed resident to use call light for assistance when needing to use bathroom." 2/28/12 1630 [4:30 p.m.] "...Uses bedside commode unassisted..." 3/1/12 0230 [2:30 p.m.] "Resident up unassisted to bathroom. alarm sounding, staff reached resident @ bedside et assisted to bathroom. Up unassisted X 4..." 3/1/12 1700 [5:00 p.m.] "...Has transferred self several times [without] assist, staff notified due to alarms sounding, reminded res. to call for assist, voiced understanding but continues to get up [without] assist." 3/2/12 1040 [10:40 a.m.] "Resident con't [continues] to get [up] [without] assistance to use BSC. Staff reminded resident to use call light for assistance [with] ambulation. Assisted back to bed per resident's request [with] assist X 1." 3/5/12 0300 [3:00 a.m.] "Awake-noncompliant-getting out of bed unassisted - sounding alarm - entered room - resident on BSC..." 3/5/12 0330 [3:30 a.m.] "Alarm sounded - entered residents room - she was in her room mates space standing holding self up [with] hand on wall talking to room mate who was sleeping..." 3/5/12 1045 [10:45 a.m.] "Resident remains anxious 1:1 provided D/T [due to] non compliance getting [up] [without]</p>						

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	<p>assistance. Daughter came in to visit et is trying to convince resident to ask for assistance..."</p> <p>3/5/12 1400 [2:00 p.m.] "Resident observed on floor lying on back @ bedside @ 0740 [7:40 a.m.]. Resident attempted to ambulate self. Call light not turned on. Bed sensor on et sounding. Resident c/o [complaint of] back et rib pain...Dr. [name] et [family name] updated."</p> <p>Resident #82's risk for falls and use of alarms was reviewed with the Quality Assurance Nurse [QA Nurse] and the Director of Nursing [DoN] on 3/6/12 at 10:20 a.m. Both indicated the resident was to have alarms in place to alert staff of unassisted transfers.</p> <p>7. Resident #94's clinical record was reviewed on 3/5/12 at 9:35 a.m. Nurses' notes included, but were not limited to, the following: 3/2/12 0400 [4:00 a.m.] "Called to resident room c/o [complaint of] pain to back...Noted discoloration on back. Asked resident if was ok. Stated, 'I didn't want to say anything but I fell a while ago on bottom hit head et back on chair.' Assessment completed. Bruise to mid lumbar 4 X 5 cm [centimeters] et hematoma to 3 X 2.5 cm [with] o/a [open area] to center 1 X 0.3 X 0.1 cm purple</p>						

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	<p>around opening. Resident didn't know she hit head that hard. Neuro [checks] initiated..."</p> <p>On 3/3/12, physician's orders were obtained for the following: bed sensor when in bed, chair sensor when up in chair, to alert staff of unassisted transfers.</p> <p>The care plan for fall risk, dated 8/25/11, was updated on 3/3/12 to include the sensor alarm in the chair and bed.</p> <p>On 3/6/12 at 8:40 a.m., Resident #94 was observed walking around in her room with a wheeled walker. No alarms were sounding.</p> <p>The resident was observed from 8:40 a.m. to 8:45 a.m. as she stood in her room and then turned around and sat on the chair seat of her walker. At 8:45 a.m., LPN #3 was interviewed regarding the care plan to prevent falls for Resident #94. She indicated they did not feel she was safe to be up on her own and alarms were supposed to be in place. She was to be up with assistance of one staff person. LPN #3 went to the resident's room and returned at 8:50 a.m. She indicated the resident had told her she had turned off the alarms.</p> <p>3.1-35(g)(2)</p>						

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure 3 of 12 residents reviewed for falls, in the total sample of 29, were provided functioning assistive devices identified by the plan of care to prevent falls, in that the residents were observed not to have the devices in place and/or had a nonfunctioning alarm in place with potential for and/or actual falls. (Residents #37, #82, #94)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #37 was reviewed on 02/28/12 at 1:30 P.M. The record indicated the diagnoses included, but were not limited to, dementia and osteoporosis.</p> <p>During the initial tour on 02/27/12 at 11:15 A.M., Unit Manager #1 indicated Resident #37 had experienced falls and was cognitively impaired. Resident #37 was observed at that time, lying in bed.</p> <p>A Fall Risk Assessment dated 11/21/11</p>	F0323	<p>The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 37 has had all safety devices checked, and they are in working order. In addition, the nursing staff has been directed to check each alarm upon each application to ensure its proper functioning status. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 82 is no longer a resident at the facility. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 94 has been reassessed related to her safety needs. The alarms have been discontinued. The resident's care plan has been up-dated, and current safety interventions are in place and functioning properly. <i>The corrective action taken for the other residents having the potential to be affected by the same alleged deficient practice is that all residents identified as a</i></p>	04/06/2012			

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	<p>indicated Resident #37 was at a high risk to fall.</p> <p>A Nurse's Note dated 02/02/12 at 1515 [3:15 P.M.] indicated, "Resident found lying on stomach on floor with face noted to be on floor. Small red area noted on center of forehead near hairline."</p> <p>An Interdisciplinary Fall Committee note, dated 02/03/12, indicated Resident #37 experienced a fall from her wheelchair on 02/02/12. The note further indicated, "Staff found self releasing seat belt alarm turned off...Intervention: Make sure alarms in place are on and sounding..."</p> <p>In an interview with QA [Quality Assurance] nurse on 03/6/12 at 10:20 A.M., she indicated the alarms were not turned on at the time of the 02/02/12 fall.</p> <p>In an interview with the DoN [Director of Nursing] on 03/06/12 at 11:30 A.M., she indicated, "...They are supposed to check alarms for function every shift."</p> <p>A Nurse's Note dated 02/09/12 at 1530 [3:30 P.M.] indicated, "Resident was in wheelchair, took off self-releasing seat belt and slid to floor..."</p> <p>An Interdisciplinary Fall Committee note, dated 02/10/12, indicated Resident #37</p>		<p>fall risk have the potential to be affected by this alleged deficient practice. The facility has conducted a house wide audit of all residents at high fall risk to ensure appropriate interventions are in place and functioning properly. <i>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur is that a mandatory in-service has been conducted for all nursing staff on the importance of ensuring that all safety devices are in place and functioning properly in accordance with each resident's individualized plan of care. 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 safety alarms. The tool includes validating that safety devices are in place in accordance with the residents' individualized plan of care and that each device is functioning properly. This tool will be completed by the Director of Nursing and/or her designee 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 quarterly Quality Assurance meeting to determine if any additional interventions are warranted.</i></p>		

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	<p>experienced a fall from the wheelchair. The note further indicated, "It was discovered that the alarm the alarm box on the back of the wheelchair had opened, thus, allowing the battery to become disconnected; therefore, the alarm did not sound."</p> <p>In an interview with the QA nurse on 03/06/12 at 10:25 A.M., she indicated the alarm was not functioning at the time of the fall on 02/09/12.</p> <p>The policy and procedure for Fall Management Program, provided by the Administrator on 02/27/12 at 1:30 P.M., indicated, "Policy: It is the policy of [name of facility] to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls."</p> <p>2. During the initial tour, on 2/27/12 at 11:47 a.m., LPN #3 indicated Resident #82 was not supposed to transfer by herself. She indicated they were using pressure alarms to alert staff if she got up, but indicated during interview at that time, "she takes it off."</p> <p>On 2/29/12 at 11:08 a.m., Resident #82</p>						

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	<p>was observed getting up from her bed to the bedside commode. No alarm sounded. While the resident was seated on the bedside commode, CNA #3 entered the room. She clipped the call light to the resident's pants, left the resident on the bedside commode, washed her hands, and left the room.</p> <p>The resident used the bedside commode, pushed the call light at 11:12 a.m., and immediately stood up and began attempting to pull up her pants and incontinence brief. She sat down when she was unable to pull up everything. CNA #3 answered the call light at 11:14 a.m. and proceeded to assist the resident.</p> <p>Resident #82's clinical record was reviewed on 2/28/12 at 11:02 a.m. The resident's diagnoses included, but were not limited to, dementia, hypertension, osteopenia, and severe degenerative disc disease. The resident had a Fall Risk Assessment, dated 2/1/12, indicated Resident #82 was at risk for experiencing a fall. The care plan, dated 2/14/12, for fall risk, included, but was not limited to, the following: -remind resident to use call light when needing assistance -up with assist of 1 -notify MD [medical doctor] and responsible party, and implement</p>			

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	<p>interventions should a fall occur</p> <ul style="list-style-type: none"> -bed sensor in bed -chair sensor in w/c [wheelchair] <p>Nurses' notes included, but were not limited to, the following:</p> <p>2/21/12 0100 [1:00 a.m.] "Resident up to BSC [bedside commode] [with] assist of 1..."</p> <p>2/21/12 2155 [9:55 p.m.] "...Resident continues to transfer self setting alarms off several times per shift, will on occasion use call light when reminded per staff, transfers [with] assist of 1."</p> <p>2/28/12 1100 [11:00 a.m.] "Resident has been non compliant numerous times alarms sounding transferring self [without] assist from BSC to W/C [wheelchair] to bed. Assigned 1:1 care for resident R/T [related to] unsafe transfers."</p> <p>2/28/12 1315 [1:15 p.m.] "Resident alert [with] confusion. continuing to get up unassisted to utilize bedside commode. Resident having frequency [with] urination...Alarm audible et functioning. Instructed resident to use call light for assistance when needing to use bathroom."</p> <p>2/28/12 1630 [4:30 p.m.] "...Uses bedside commode unassisted..."</p> <p>3/1/12 0230 [2:30 p.m.] "Resident up unassisted to bathroom. alarm sounding, staff reached resident @ bedside et</p>			

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	<p>assisted to bathroom. Up unassisted X 4..."</p> <p>3/1/12 1700 [5:00 p.m.] "...Has transferred self several times [without] assist, staff notified due to alarms sounding, reminded res. to call for assist, voiced understanding but continues to get up [without] assist."</p> <p>3/2/12 1040 [10:40 a.m.] "Resident con't [continues] to get [up] [without] assistance to use BSC. Staff reminded resident to use call light for assistance [with] ambulation. Assisted back to bed per resident's request [with] assist X 1."</p> <p>3/5/12 0300 [3:00 a.m.] "Awake-noncompliant-getting out of bed unassisted - sounding alarm - entered room - resident on BSC..."</p> <p>3/5/12 0330 [3:30 a.m.] "Alarm sounded - entered residents room - she was in her room mates space standing holding self up [with] hand on wall talking to room mate who was sleeping..."</p> <p>3/5/12 1045 [10:45 a.m.] "Resident remains anxious 1:1 provided D/T [due to] non compliance getting [up] [without] assistance. Daughter came in to visit et is trying to convince resident to ask for assistance..."</p> <p>3/5/12 1400 [2:00 p.m.] "Resident observed on floor lying on back @ bedside @ 0740 [7:40 a.m.]. Resident attempted to ambulate self. Call light not turned on. Bed sensor on et sounding.</p>			

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	<p>Resident c/o [complaint of] back et rib pain...Dr. [name] et [family name] updated."</p> <p>Resident #82's risk for falls and use of alarms was reviewed with the Quality Assurance Nurse [QA Nurse] and the Director of Nursing [DoN] on 3/6/12 at 10:20 a.m. Both indicated the resident was to have alarms in place to alert staff of unassisted transfers.</p> <p>3. Resident #94's clinical record was reviewed on 3/5/12 at 9:35 a.m. Nurses' notes included, but were not limited to, the following: 3/2/12 0400 [4:00 a.m.] "Called to resident room c/o [complaint of] pain to back...Noted discoloration on back. Asked resident if was ok. Stated, 'I didn't want to say anything but I fell a while ago on bottom hit head et back on chair.' Assessment completed. Bruise to mid lumbar 4 X 5 cm [centimeters] et hematoma to 3 X 2.5 cm [with] o/a [open area] to center 1 X 0.3 X 0.1 cm purple around opening. Resident didn't know she hit head that hard. Neuro [checks] initiated..."</p> <p>On 3/3/12, physician's orders were obtained for the following: bed sensor when in bed, chair sensor when up in chair, to alert staff of unassisted transfers.</p>						

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	<p>The care plan for fall risk, dated 8/25/11, was updated on 3/3/12 to include the sensor alarm in the chair and bed.</p> <p>On 3/6/12 at 8:40 a.m., Resident #94 was observed walking around in her room with a wheeled walker. No alarms were sounding.</p> <p>The resident was observed from 8:40 a.m. to 8:45 a.m. as she stood in her room and then turned around and sat on the chair seat of her walker. At 8:45 a.m., LPN #3 was interviewed regarding the care plan to prevent falls for Resident #94. She indicated they did not feel she was safe to be up on her own and alarms were supposed to be in place. She was to be up with assistance of one staff person. LPN #3 went to the resident's room and returned at 8:50 a.m. She indicated the resident had told her she had turned off the alarms.</p> <p>3.1-45(a)(2)</p>				

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F0371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored in a sanitary manner, for 1 of 3 kitchen areas (Main Kitchen), in that carrot cake was stored uncovered and undated, unsealed packages of noodles and fish fry mix were present, and rotting produce was present in the dry storage area. This had the potential to affect 113 of 113 residents being provided food from the main kitchen, in a facility certified census of 189.</p> <p>Findings Include:</p> <p>During the initial tour of the kitchen on 2/27/12 at 10:15 a.m., observations in the dry storage area included: three trays of carrot cake uncovered and without a preparation date, an unsealed open bag of noodles without the opening date, an unsealed open bag of fish fry mix without the opening date, and a rotten banana on the shelf.</p> <p>In an interview with the Director of Food</p>	F0371	<p>The corrective action taken for those residents found to be affected by the alleged deficient practice is that no individual residents were identified during the survey. <i>The corrective action taken for the other residents having the potential to be affected by the same alleged deficient practice is that all residents had the potential to be affected by the deficient practice.</i> The three trays of carrot cake that were in an enclosed food cart identified during the survey were disposed of immediately. The open bag of noodles that was identified as unsealed and undated was actually sealed with masking tape and was dated at the time noted during the survey. The open bag of fish fry mix and the one rotten banana were immediately disposed of at the time identified during the survey. The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur is that a mandatory in-service was conducted for all dietary staff on the facility policies related to sanitary food storage. <i>The</i></p>	04/06/2012			

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	<p>Services on 3/6/12 at 11:30 a.m., she indicated the uncovered carrot cake was left over from the weekend prior to the initial tour of the kitchen on 2/27/12. In the interview, the Director of Food Services acknowledged observations of the uncovered carrot cake without a preparation date, an unsealed open bag of noodles without a date of opening, an open bag of fish fry mix without the date of opening and a rotten banana, all in the dry storage area.</p> <p>A document titled Food Storage Policy and Procedure was provided on 3/6/12 at 02:00 p.m. by the Director of Food Services. The document indicated the policy of the facility was to store food to ensure quality and safe condition. The document also indicated food items not in their original package were to be covered, dated, and labeled per contents.</p> <p>3.1-21(i)(3)</p>		<p><i>corrective action taken to monitor to assure performance to assure compliance through quality assurance is the facility will utilize a dietary audit tool to monitor for compliance. The tool includes sanitary storage of food items. This tool will be completed by the Director of Dietary Services weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this audit tool will be reviewed at the quarterly Quality Assurance meeting to determine if additional interventions are warranted.</i></p>		

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure gloves were</p>	F0441	The corrective action taken for those residents found to be	04/06/2012	

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	<p>changed and hands were washed between soiled and clean activities, for 2 of 8 residents observed during care, in the sample of 29. (Residents #182, #37)</p> <p>Findings include:</p> <p>1. During observation on 2/28/12 at 10:30 A.M., Resident #182 had the dressing to his buttock wound changed by the P.T. [physical therapist]. P.T. #1 washed her hands and applied her gloves after obtaining the supplies. Resident #182 was soiled with feces and P.T. #1 cleaned the resident and applied a clean brief to the resident. P.T. #1 removed her gloves and washed her hands after cleaning the resident and discarding the soiled items. P.T. #1 then applied new gloves and removed Resident #182's soiled dressing from his buttock wound. P.T. #1 then cleansed the wound with normal saline and used tweezers to debride the wound. P.T. #1 then applied ointment and checked the area around the wound. A border foam dressing was then applied by P.T. #1. After applying the dressing, P.T.#1 removed the gloves and proceeded to wash her hands. She failed to wash her hands between the soiled dressing the clean dressing.</p>		<p>affected by the alleged deficient practice is that the resident identified as Resident # 182 is receiving his wound treatment in accordance with acceptable standards of infection control practices. The corrective action taken for those residents found to be affected by the alleged deficient practice is that the resident identified as Resident # 37 is receiving incontinent care in accordance with acceptable standards of infection control practices. <i>The corrective action taken for the other residents having the potential to be affected by the same alleged deficient practice is that all residents have the potential to be affected by the alleged deficient practice. The staff members are providing personal care and treatments to all residents in accordance with acceptable standards of infection control practices. The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur is that the facility has conducted a mandatory in-service for all nursing and physical therapy staff on the proper use of gloves and hand hygiene. The in-service included a review of the facility policy and procedures on hand washing and glove usage. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance</i></i></p>		

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	<p>2. During observation of care on 02/28/12 at 8:40 A.M., CNA #4 and CNA #5 were observed to apply gloves and transfer Resident #37 from the wheelchair to the toilet. CNA #4 indicated at that time the resident had been incontinent of urine. Both CNA's were observed to assist with the removal of the saturated incontinence brief. Both CNAs were observed to remove their gloves and apply new gloves without performing hand hygiene. CNA #4 was then observed to provide perineal care to Resident #37 and remove the gloves. CNA #4 was then observed to apply new gloves without performing hand hygiene and apply a barrier cream to the perineal area. At that time CNA #5 was observed to dress</p>		<p>tool has been developed and implemented to monitor infection control practices as it relates to hand washing and glove usage. The tool includes observations of the staff providing personal care and treatments for the residents to ensure acceptable standards of infection control practices are followed. This tool will be completed by the Director of Infection Control weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of this tool will be reviewed at the quarterly Quality Assurance meeting to determine if additional interventions are warranted.</p>	

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	<p>Resident #37.</p> <p>3. The policy and procedure for "Using Gloves," dated 3/2012, was provided by the Quality Assurance Nurse on 3/6/12 at 3:55 p.m. The policy and procedure included, but was not limited to, the following: "Objectives: To prevent the spread of infection and disease to residents and employees; To protect wounds from contamination; To protect hands from potentially infectious material..." "Miscellaneous: "Wash hands after removing gloves. Gloves do not replace handwashing."</p> <p>3.1-18(l)</p>				

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R0298	<p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on observation and interview, the facility failed to ensure the consultant pharmacist reviewed the drug regimen every 60 days for 2 of 3 sampled residents whose medications were handled by the facility, in the sample of 6, in that it had been greater than 60 days since review. (Resident #204, #205)</p> <p>Findings include:</p> <p>1. Resident #204's clinical record was reviewed on 3/2/12 at 9:45 a.m. The resident was admitted to the facility in November, 2010. The physician's orders, dated 1/11/12, indicated the facility administered the resident's medications. The last documented review of the medications by the pharmacist was on</p>	R0298	<p>The corrective action taken for those residents found to be affected by the alleged deficient practice is that the residents identified as Residents # 204 and # 205 have had their medications reviewed by the consultant pharmacist. <i>The corrective action taken for the other residents having the potential to be affected by the same alleged deficient practice is that all residential residents have the potential to be affected by the alleged deficient practice. The consultant pharmacist conducted a house wide review of all residential residents to ensure that a medication review had been completed in a timely manner. The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur</i></p>	04/06/2012			

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	<p>11/9/11.</p> <p>2. Resident #205's clinical record was reviewed on 3/2/12 at 10:15 a.m. The resident was admitted in April, 2010. Physician's orders dated 9/10/11 indicated the facility administered the resident's medications. The last documented review of the medications by the pharmacist was on 11/9/11.</p> <p>3. Interview with the Administrator, on 3/6/12 at 3:00 p.m., indicated the pharmacist thought they only needed to review every 6 months.</p>		<p><i>is that</i> the consultant pharmacist has been educated on the residential requirements as it relates to medication reviews and has established a routine schedule whereby all residential residents will have their medications reviewed every 60 days. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a</i> Quality Assurance Tool has been developed and implemented to audit residential clinical records to ensure that medication reviews have been conducted by the consultant pharmacist every 60 days. This tool will be completed by the Administrator and/or her designee weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The outcomes of this tool will be reviewed at the quarterly Quality Assurance meeting to determine if any additional interventions are warranted.</p>		