

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 29, March 1, 2, 5, 6, 7, 2012</p> <p>Facility Number: 000033 Provider Number: 155375 AIM Number: 100266280</p> <p>Survey Team: Martha Saull, RN TC Carole McDaniel, RN Terri Walters, RN (2/29, 3/1/12) Dorothy Watts, RN</p> <p>Census Bed Type: SNF/NF: 56 Total: 56</p> <p>Census By Payor Source: Medicare: 6 Medicaid: 45 Other: 5 Total: 56</p> <p>Sample: 13</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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

PRINTED: 03/29/2012

FORM APPROVED

OMB NO. 0938-0391

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	Quality review 3/14/12 by Suzanne Williams, RN			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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>A. Based on observation, record review and interview, the facility failed to provide a specific plan of care for utilizing and monitoring anti pressure equipment for pressure sore treatment of 1 of 1 resident reviewed for pressure sores of 1 who met the criteria of Stage III- IV pressure sores. Resident #9</p> <p>B. Based on interview and record review, the facility failed to ensure a care was developed for insomnia for a resident who did not have alternative interventions offered</p>	F0279	<p>What correction action will be accomplished for those residents found to have been affected by the deficient practice: Resident #9 POC updated to include: facility to follow manufactures guidelines. Resident #9 was moved to window bed to assist in the touch control panel not being hit by mechanical lift. Inservice conducted by 4/6/12 to nursing staff on settings of air-flow mattresses. TAR's and CNA assignment sheets have been updated to include the current settings. Resident #77 Care Plan updated</p>	04/06/2012	

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	<p>and/or implemented prior to administration of medication used for sleep, for 1 of 10 residents reviewed for unnecessary medications in a Stage 2 sample of 13. Resident #77</p> <p>Findings include:</p> <p>A. The clinical record of Resident #9 was reviewed on 3/02/12 at 9:00 A.M. Diagnoses included but were not limited to Multiple Sclerosis and a Stage IV pressure ulcer of the right lateral trochanter (a full thickness of tissue loss over the hip bone).</p> <p>The 10/08/10 Care Plan addressed the care of the wound with interventions which included but were not limited to alleviation of pressure on the area by means of a Wound Care 300 mattress (a low air loss mattress with an alternating pressure mechanism). The Care Plan directed "check every shift for malfunction."</p> <p>On 3/2/12 at 11:30 A.M., the mattress was observed in use for Resident #9. Directly inside the door of the bedroom the touch control panel was located at the foot end of the bed. It had various operational settings including a range of numbers to choose the amount of pressure</p>		<p>to include alternate interventions prior to administration of PRN Hypnotic medication. Hypnotic medication was discontinued.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents who are placed on an air-flow mattress upon admission or placed on mattress, the DNS/or Designee will review for proper weight settings and care plan. TAR's and CNA assignment sheets have been updated to include the current settings. DNS or Designee reviewed all residents with Hypnotic medications for appropriate care plan.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Residents who are placed on an air-flow mattress upon admission or placed on mattress, the DNS/or Designee will review for proper weight settings and care plan. TAR's and CNA assignment sheets have been updated to include the current settings. DNS or Designee reviewed all residents with Hypnotic medications for appropriate care plan. Licensed staff will be inserviced by 4/6/12 of the need</p>		

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	<p>depending on the weight of the resident. At that time, the mattress was set on 4 which was the setting indicated for use with a resident weight of 175 lbs.</p> <p>On 3/05/12 at 10:10 A.M. the setting with the mattress in use was 9 which was the setting the panel indicated was for use with a resident weight of 350 lbs. At that time LPN # 1 was interviewed regarding the use of the mattress. She indicated the resident weighed 158-159, and the pressure mattress setting she used was 3 indicated for a resident weight of 140, since it afforded less pressure on the pressure sore being treated. She indicated she had already changed the dressing that morning and had documented on the treatment administration record (TAR) that the mattress was functioning properly. The documentation was to be entered by each nurse once each shift. Review of that documentation at that time identified nurses were documenting checking "wound Care 300 mattress to bed for pressure relief, check every shift for malfunction." After being informed, LPN #1 rechecked the mattress setting, observed it to be 9 and stated "Oh my, that's too high, too much pressure."</p>		<p>to develop a plan of care for those residents with a diagnosis of insomnia and the need for non-pharmacological interventions to be utilized.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Air Flow mattresses will be monitored by nurse and documented on TARS daily times 3. CNA assignment sheets have correct settings for each resident air-flow mattress. Manufacturers guidelines connected to bed for immediate reference. DNS/Designee to monitor by observation during daily rounds. Report of findings during daily rounds will be given to the QA&A committee. On admission and daily start up the DNS/Designee will review for Hypnotic PRN medications for POC. IDT team to review during scheduled care plan meetings. This will be monitored through facility QA&A monthly meeting times 3 months then quarterly times 3 then as needed.</p> <p>Date the systemic changes will be completed: 4/6/12</p>		

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	<p>On 3/05/12 at 10:15 A.M. CNA #1 and CNA #2 were interviewed. They indicated they provided care to Resident #9. Neither was aware of the control panel settings and indicated the nurses took care of that. The assignment sheets, provided to the CNAs summarized individualized plan of care interventions for each resident for which they were providing care. Their assignment sheets, reviewed at that time, did not indicate mattress settings. CNA #1 indicated the panel was located in a spot which was easily touched and could be "bumped or changed anytime when we bring that lift in and out and try to get by but we can watch for that and be sure it's set right or tell the nurse" if it is incorrect " we really didn't know anything about it."</p> <p>On 3/05/12 at 11:00 A.M. the Director of Nursing was interviewed. She indicated documentation was lacking of the specific mattress panel settings planned to be in use for Resident # 9. She indicated the manufacturer operation manual for the mattress was not available and was later faxed to the facility at 12:20 P.M. The manual indicated 3 individualized settings beside position of the mattress: Alternating pressure</p>			
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	<p>button, pressure number according to resident weight and Mode operation to distinguish Max inflate/ Low air loss. Documentation was lacking to indicate the specific plan for Resident #9 for any of the settings.</p> <p>B. On 3/6/12 at 10 A.M., the clinical record of Resident #77 was reviewed. This resident was admitted to the facility on 2/11/12. Diagnoses included, but were not limited to, the following: seizures, anxiety, depression, cerebral infarction and hemiplegia affecting dominant side.</p> <p>An MDS (minimum data set assessment) dated 2/26/12 indicated the resident utilized the medication valium for sleep.</p> <p>Documentation was lacking of a plan of care for the resident's problem of insomnia.</p> <p>At this time, the resident's February 2012 MAR (medication administration record) and March 2012 was reviewed. This indicated the resident was medicated on the following dates with valium 2 mg: 2/20, 2/21, 2/22, 2/24, 2/25 and 2/28. This form indicated the following physician order dated 2/10/12: "Diazepam 2 mg, 2 tabs (tablets)...q (every) hs</p>						

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	<p>(bedtime)...prn (as needed) for sleep." The March 2012 MAR indicated the following dated 2/12/2012: "Diazepam 2 mg...2 tabs...at hs...prn..." Nursing notes for the above dates were also reviewed. Documentation was lacking as to alternative interventions offered and/or implemented prior to medication of the resident for sleep.</p> <p>On 3/7/12 at 10 A.M., the DON (Director of Nursing) was interviewed. At this time, she reviewed the resident's clinical record. She indicated there was no care plan on the clinical record to address the resident's insomnia and/or alternate interventions that should have been offered and/or attempted prior to medicating the resident. The DON provided a copy of the "Clinical Health Status" form, completed on 2/26/12. This form identified the following: "...diazepam..." was used prn for sleep.</p> <p>On 3/7/12 at 11 A.M., the DON provided a copy of a care plan, dated 3/7/12 to address "Resident requires medication r/t (related to) complaints of insomnia." This care plan included, but was not limited to, the following interventions: "Provide quiet, dark room for sleep, talk to</p>						

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	resident to find out reasons for not sleeping..." 3.1-48(a)(4) 3.1-35(a)			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure correct use of anti pressure equipment for pressure sore treatment of 1 of 1 resident reviewed for pressure sores of 1 who met the criteria of Stage III- IV pressure sores. Resident #9</p> <p>Findings include:</p> <p>The clinical record of Resident #9 was reviewed on 3/02/12 at 9:00 A.M. Diagnoses included but were not limited to Multiple Sclerosis and a Stage IV pressure ulcer of the right lateral trochanter (a full thickness of tissue loss over the hip bone).</p> <p>The resident was routinely taken to a hospital based wound clinic for treatment of the pressure sore. The pressure sore was also being treated daily by facility nurses who cleansed,</p>	F0314	<p>What correction action will be accomplished for those residents found to have been affected by the deficient practice: Resident #9 was moved to window bed to assist in the touch control panel not being hit by mechanical lift. Inservice conducted by 4/6/12 to nursing staff on settings of air-flow mattresses.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents who are placed on an air-flow mattress upon admission or placed on mattress, the DNS/or Designee will review for proper weight settings and care plan.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p>	04/06/2012	

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	<p>packed and bandaged the sore.</p> <p>The 10/08/10 Care Plan addressed the care of the wound with interventions which included, but were not limited to, alleviation of pressure on the area by means of a Wound Care 300 mattress (a low air loss mattress with an alternating pressure mechanism). The Care Plan directed "check every shift for malfunction."</p> <p>On 3/2/12 at 11:30 A.M., the mattress was observed in use for Resident #9. Directly inside the door of the bedroom the touch control panel was located at the foot end of the bed. It had various operational settings including a range of numbers to choose the amount of pressure depending on the weight of the resident. At that time, the mattress was set on 4 which was the setting indicated for use with a resident weight of 175 lbs.</p> <p>On 3/05/12 at 10:10 A.M. the setting with the mattress in use was 9 which was the setting the panel indicated was for use with a resident weight of 350 lbs. At that time LPN # 1 was interviewed regarding the use of the mattress. She indicated the resident weighed 158-159 and the pressure mattress setting she used was 3</p>		<p>Residents who are placed on an air-flow mattress upon admission or placed on mattress, the DNS/or Designee will review for proper weight settings and care plan. Proper weight settings will be placed on the resident's TAR and nurse aide assignment sheet. Mattress settings will be reviewed after residents weight is obtained and corrected if necessary.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Air Flow mattresses will be monitored by nurse and documented on TARS daily times 3. CNA assignment sheets have correct settings for each resident air-flow mattress. Manufacturers guidelines connected to bed for immediate reference. DNS/Designee to monitor during by observation during daily rounds. This will be monitored through facility QA&A monthly meeting times 3 months then quarterly times 3 then as needed.</p> <p>Date the systemic changes will be completed: 4/6/12</p>				

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	<p>indicated for a resident weight of 140 since it afforded less pressure on the pressure sore being treated. She indicated she had already changed the dressing that morning and had documented on the treatment administration record (TAR) that the mattress was functioning properly. The documentation was to be entered by each nurse once each shift. Review of that documentation at that time identified nurses were documenting checking "wound Care 300 mattress to bed for pressure relief, check every shift for malfunction." After being informed, LPN #1 rechecked the mattress setting, observed it to be 9 and stated "Oh my that's too high, too much pressure."</p> <p>On 3/05/12 at 10:15 A.M. CNA #1 and CNA #2 were interviewed. They indicated they provided care to Resident #9. Neither was aware of the control panel settings and indicated the nurses took care of that. Their assignment sheet, reviewed at that time, did not indicate mattress settings. CNA #1 indicated the panel was located in a spot which was easily touched and could be "bumped or changed anytime when we bring that lift in and out and try to get by but we can watch for that and be sure it's</p>						

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	<p>set right or tell the nurse" if it is incorrect " we really didn't know anything about it."</p> <p>On 3/05/12 at 11:00 A.M. the Director of Nursing was interviewed. She indicated documentation was lacking of the specific mattress panel settings to be in use for Resident # 9. She indicated the manufacturer operation manual for the mattress was not available and was later faxed to the facility at 12:20 P.M. The manual indicated 3 individualized settings beside position of the mattress: Alternating pressure button, pressure number according to resident weight and Mode operation to distinguish Max inflate/ Low air loss. Documentation was lacking of monitoring of any of the settings.</p> <p>On 3/05/12 1:30 P.M. the pressure sore measurements from the wound clinic were reviewed: 12/28/11 0.2 cm length 0.3 cm width 3.0 cm depth 01/18/12 0.2 cm length 0.3 cm width 3.2 cm depth 02/08/12 0.4 cm length 0.3 cm width 2.5 cm depth 02/29/12 0.2 cm length 0.4 cm width 3.4 cm depth.</p> <p>3.1-40(a)(2)</p>						

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure alternative interventions were offered and/or implemented prior to administration of medication used for sleep for 1 of 10 residents reviewed for unnecessary medications. Resident #77</p> <p>Findings include: On 3/6/12 at 10 A.M., the clinical record of Resident #77 was reviewed.</p>	F0329	<p>What correction action will be accomplished for those residents found to have been affected by the deficient practice: Resident #77 Plan of Care completed to include alternative non-pharmacological interventions were offered and/or implemented prior to administration of medication. An Intervention Attempted form placed behind medication record to record interventions.</p> <p>How other residents having the</p>	04/06/2012

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
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	<p>This resident was admitted to the facility on 2/11/12. Diagnoses included, but were not limited to, the following: seizures, anxiety, depression, cerebral infarction and hemiplegia affecting dominant side.</p> <p>An MDS (minimum data set assessment) dated 2/26/12 indicated the resident utilized the medication valium for sleep.</p> <p>Documentation was lacking of a plan of care for the resident's problem of insomnia.</p> <p>At this time, the resident's February 2012 MAR (medication administration record) and March 2012 was reviewed. This indicated the resident was medicated on the following dates with valium 2 mg: 2/20, 2/21, 2/22, 2/24, 2/25 and 2/28. This form indicated the following physician order dated 2/10/12: "Diazepam 2 mg, 2 tabs (tablets)...q (every) hs (bedtime)...prn (as needed) for sleep." The March 2012 MAR indicated the following dated 2/12/2012: "Diazepam 2 mg...2 tabs...at hs...prn for seizures." Nursing notes for the above dates were also reviewed. Documentation was lacking as to alternative interventions offered and/or</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All resident records were reviewed and found no other resident with PRN Hypnotic medication. If a resident has an order for a PRN Hypnotic medication an Intervention Attempted form will be placed behind the medication record to record the interventions, and a plan of care will be developed to reflect non-pharmacological interventions.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; If a resident has an order for a PRN Hypnotic medication an Intervention Attempted form will be placed behind the medication record to record the interventions. Licensed staff will be inserviced by 4/6/12 on the use of non-pharmacological interventions and the use of the Interventions Attempted form. DNS or designee will review 5 times weekly for proper interventions being recorded.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place DNS/Designee to</p>		

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	<p>implemented prior to medication of the resident for sleep.</p> <p>On 3/7/12 at 10 A.M., the DON (Director of Nursing) was interviewed. At this time, she reviewed the resident's clinical record. She indicated there was no care plan on the clinical record to address the resident's insomnia and/or alternate interventions that should have been offered and/or attempted prior to medicating the resident. The DON indicated she was unsure why the prn Diazepam was documented of usage for sleep on the February MAR and for seizures on the March MAR. The DON provided a copy of the "Clinical Health Status" form, completed on 2/26/12. This form identified the following: "...diazepam..." was used prn for sleep.</p> <p>On 3/7/12 at 11 A.M., the DON provided a copy of a care plan, dated 3/7/12 to address "Resident requires medication r/t (related to) complaints of insomnia." This care plan included, but was not limited to, the following interventions: "Provide quiet, dark room for sleep, talk to resident to find out reasons for not sleeping..."</p> <p>3.1-48(a)(4)</p>		<p>monitor by observation during daily rounds for proper interventions being recorded if facility has a resident with PRN Hypnotic medications. This will be monitored through facility QA&A monthly meeting times 3 months then quarterly times 3 then as needed.</p> <p>Date the systemic changes will be completed: 4/6/12</p>				

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on observation, interview, and record review, the facility failed to ensure significant medication errors did not occur, related to the failure to administer medication as ordered by a physician and to follow the policy and procedure for proper administration of medication, for 1 of 15 residents observed during medication pass. Resident # 77.</p> <p>Findings included:</p> <p>During observation of medication administration on 3/5/2012 at 3:35 P.M., on the East hall, RN #18 took 4 Dilantin 100 mg capsules (medication for seizures) out of their packaging and placed them in the medication cup along with other medications to dispense to Resident #77. At this time, RN #18 was made aware of the number of Dilantin capsules she had prepared to dispense. RN #18 was interviewed at this time. She stated "Oh, I must have pulled the Dilantin twice." She indicated at this time, she thought the resident was to get a total of 200mg. RN #18 then reviewed the medication record and then removed</p>	F0333	<p>What correction action will be accomplished for those residents found to have been affected by the deficient practice: DNS or designee completed an incident report of medication error. Physician and resident notified. Nurse #18 counseled on medication error.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. Licensed nurses will have completed competencies (which includes on site review of medication pass) on medication administration by 4/6/12.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Each licensed staff will have a competency in medication pass completed at a minimum of yearly. Random competencies will be conducted by DNS/Designee on licensed staff with a minimum of five nurses quarterly.</p>	04/06/2012	

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	<p>2 Dilantin 100 mg capsules, from the medication cup. This left 2, 100 mg capsules of Dilantin in the cup.</p> <p>The record review on 3/5/2012 at 4:02 P.M. of the current physician's order indicated the following: On 2/12/2012 Phenytoin (Dilantin) Extended 300 mg twice a day, by mouth for seizures.</p> <p>The record review on 3/5/2012 at 4:05 P.M., indicated Resident #77's laboratory report indicated his Dilantin level to be low at 6.1, on 2/16/12. The therapeutic range for Dilantin level would be 10.2 - 20.</p> <p>A Policy and Procedure for Medication Administration, dated 9/2008, was provided by the DON on 3/5/2012 at 1:15 P.M. It indicated, prior to administration, the medication and dosage schedule on the resident's Medication Record is compared with the medication label. If the label and the Medication Record are different, or if there is any reason to question the dosage or direction, the prescribe's orders are checked for the correct dosage schedule.</p> <p>3.1-48(c)(2)</p>		<p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Results of competencies will be monitored through facility QA&A monthly meeting times 3 months then quarterly times 3 then as needed.</p> <p>Date the systemic changes will be completed: 4/6/12</p>				

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F0371 SS=F	<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, record review and interview, the facility failed to ensure sanitary food preparation practices and dinnerware storage during 2 of 2 observations, with the potential to impact 55 residents being served meals prepared in the kitchen of 56 residents.</p> <p>Findings include:</p> <p>During the kitchen observation on 3/06/12 at 11:25 A.M. Cook #1 was observed to be cooking the noon meal. She indicated she had cooked breakfast,"eggs and all" earlier but had no food preparation sanitizer made since she had "not needed it." She indicated she only used it "if I have a big mess but I haven't had one yet." She indicated food spills and splatters were wiped with a dry rag. At that time she opened her smock pocket to show 4 dry rags she had been using. There were 3 food thermometers stored for use in a glass of odorless clear liquid with the</p>	F0371	<p>What correction action will be accomplished for those residents found to have been affected by the deficient practice: Dietary staff will be inserviced by 4/6/12 for proper maintenance of sanitation buckets, sanitation of food surfaces and testing of solution. Microwave oven was cleaned. New plates, muffin pans, frying pans and gray insulation plates ordered. Clipboards replaced with clean plastic clipboards for easy sanitation. Staff instructed not to use two compartment sink for food preparation except cleaning of vegetables.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. Dietary staff will be inserviced by 4/6/12 on proper maintenance of sanitation buckets, sanitation of food surfaces, testing of solution, proper storage of clean dishes and cleaning of equipment.</p>	04/06/2012			

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	<p>appearance of water. Cook #1 indicated the solution was a sanitizing solution made automatically from a Quat dispenser at the sink. The Food Service Manager tested the solution and no sanitation chemical was detected.. The Food service manager then prepared a fresh bucket of sanitation solution for Cook #1 to use on the food prep counter. It was tested and also identified no chemical content. She mixed a fresh bucket and then determined the water at the sink had to be run until the level of pink chemical solution was visible in the clear delivery tube in order to deliver the desired chemical. That solution tested at 200 ppm (parts per million) strength as the FSS intended. She instructed Cook #1 and Dietary Staff Assistant what she had determined.</p> <p>The 2012 current Policy and Procedure for food surface sanitation solution indicated the 200 ppm solution strength was correct. The solution was to be utilized before and after the preparation of each meal and as needed to wipe the surface during food preparation. It directed rags in use during a meal were to be stored solution and discarded to soiled linen after use.</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff will be inserviced by 4/6/12 for proper maintenance of sanitation buckets, sanitation of food surfaces, testing of solution, proper storage of clean dishes and cleaning of equipment. Audits will be conducted 5 times per week for 4 weeks then 3 times per week for 4 weeks, then random as needed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Dietary Service Manager/Designee will conduct audits 5 times per week for 4 weeks then 3 times per week for 4 weeks, then random as needed. This will be reviewed monthly during facility QA&A meeting for 3 months then quarterly times 3 months then as needed.</p> <p>Date the systemic changes will be completed: 4/6/12</p>				

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	<p>Also on 3/06/12 at 12:05 P.M., the microwave was observed to have its outside door and operation panel sticky with dried food matter adhering and its interior spattered with accumulated dried food mater.</p> <p>On 3/06/12 at 12:10 P.M., there were 8 of 8 trays stored as clean and stacked wet with trapped water in between them. There were 2 of 2 plastic gallon pitchers stored for use inverted on a surface with visible water trapped inside and pooling on the surface.</p> <p>There were 3 of 3 muffin tins and 2 of 4 fry pans stored for use with dried food matter and/or nonstick finish flaking off the interior surfaces. There were 3 of 7 gray plastic insulation dishes for dinner plates which were chipped and cracked with rough edges. There were 9 of 10 white commercial china dinner plates with surfaces worn off at the center and deep discolored scratches.</p> <p>On 3/07/12 at 10:00 A.M. Cook #2 was preparing the lunch meal while wearing and occasionally adjusting a wide wrist watch. She indicated the ground meat on the food prep surface was Polish sausage she had ground. The food prep surface had not been sanitized and there was no sanitizing</p>						

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	<p>solution prepared; however, the cook had to place articles on the surface during preparation of the next item. There was a large can of sauerkraut opened, a stack of clean single serving bowls and 2 bowls free standing, menu spread sheets and recipes along with the blender used to grind the meat and the loose meat. One clip board was placed on the food debris surface which was made of pressed particle board whose edges had deteriorated and corners were worn off with the metal clip mechanism oxidized. The Registered Dietician, in the kitchen at that time, indicated she was preparing sanitizing solution for the cook to use and noted the clip board was supposed to be hanging on a hook rather than placed on the food prep surface.</p> <p>3.1-21(i)(3)</p>			

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications refused by a resident were disposed of properly, according to their pharmacy policy and procedure, for 1 of 15 residents reviewed during medication pass. Resident #25</p> <p>Findings included:</p> <p>During observation of the medication cart on the Alzheimer unit on 3/5/2012 at 10:15 A.M., an opened medication cup containing 8 loose tablets was observed in the</p>	F0425	<p>What correction action will be accomplished for those residents found to have been affected by the deficient practice: Two licensed nurses destroyed the medication properly.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. Nurses will sign prepared form in medication book during change of shift that medication cart is free of</p>	04/06/2012			

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	<p>medication drawer labeled Resident #25. The cup was not labeled with a name, date, or time.</p> <p>During an interview on the Alzheimer unit with RN# 17 on 3/5/2012 at 11:05 A.M., she indicated the medications in the cup, were left from the third shift medication pass. She indicated Resident# 25 refused to take the medication. RN # 17 said, "Hopefully the night nurse would have let the day shift nurse know if a patient had refused medication and the 2 nurses would have attempted to give the medication to the resident at shift change."</p> <p>Record review on 3/06/2012 at 3:15 P.M., the facility's Nursing Care Center Pharmacy Policy and Procedures for Disposal of Medication which was provided by the DON on 3/6/2012 at 1:15 P.M., indicated: once a medication has been removed from the package and not used, it shall be destroyed by nursing care center in the presence of a nurse, pharmacist and one other witness as per state regulation. Documentation of non-controlled medication may be completed on the medication administration record.</p> <p>Record review of the medication</p>		<p>medications in cup not dispensed to a resident. Medications needing to be destroyed during medication pass will be placed in a covered container until completion of medication pass when two licensed nurses can destroy the medication.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurses will sign prepared form in medication book during change of shift that medication cart is free of medications in cup not dispensed to a resident. Medications needing to be destroyed during medication pass will be placed in a covered container until completion of medication pass when two licensed nurses can destroy the medication. Licensed staff will be inserviced by 4/6/12.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DNS/designee will monitor during daily rounds 5 times week for 4 weeks, 3 times week for 4 weeks then as needed for completion of prepared form. This will be reviewed monthly during facility QA&A meeting for 3 months then</p>				

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	<p>administration record for 3/5/2012 indicated Resident #25 refused the 3/5/2012, 6:00 A.M. dose. This was indicated by the circle around the nurses initials.</p> <p>During an interview with RN # 16, on 3/5/2012 at 11:45 A.M., she indicated if a Resident refuses their medications, she immediately disposes of the medication, circles her initials, and documents the circumstances of the refusal.</p> <p>The DON indicated on 3/7/2012 at 2:35 A. M., Resident # 25's medication should not have been left in the drawer.</p> <p>3.1-25(o)</p>		<p>quarterly times 3 months then as needed.</p> <p>Date the systemic changes will be completed: 4/6/12</p>	

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F0463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation, interview and record review, the facility failed to ensure resident bathroom call lights were reliably functional for 7 of 10 resident bathrooms on 2 of 3 units (west hall and ACU [Alzheimer care unit]) in the facility reviewed during the Stage 1 sample review of 40 residents. Room #107, 110, 111, 112, 108, 101 and 102.</p> <p>Findings include:</p> <p>On 2/29/12 at 10:50 A.M., room 111 (in the west hall) was toured. It was determined at that time, the bathroom call light did not function properly. At 11:01 A.M., Nurse #19 was made aware of the call light in this room not functioning properly. At that time, Nurse #19, then notified the maintenance man and the Administrator. By 11:20 A.M., it was determined that the following 6 additional bathroom call lights did not function properly: #107, 110, 112, 108, 101 and 102. At this time, the maintenance man was observed</p>	F0463	<p>What correction action will be accomplished for those residents found to have been affected by the deficient practice: All residents were given bells to summon for assistance. Facility contracted with company to replace entire call light system. The construction of the new system began on 3/5/12.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. Random audits of 10 rooms per day will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks. After that call lights checks will be conducted during daily maintenance building engines room checks conducted monthly or as needed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Random audits of 10 rooms per</p>	04/06/2012

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	<p>beginning to repair the call lights. Within 30 minutes of the repair of 3 of the call lights, the call light function was again tested. At this time, 2 of the 3 call lights (room 107 and 110) the maintenance man had repaired were not functioning properly again. Maintenance was notified of the second failure of the bathroom call lights in room 107 and 110.</p> <p>On 2/29/12 at 11:15 A.M., the Maintenance Man was interviewed. He indicated (name of the call light repair company) had been called today and they were coming on Friday to check the system and determine the cause of the problem. He indicated he had repaired 3 of the lights and he said the problem was possibly due to the fact the lights were connected by a loop system and when one fails, the others on the loop fail.</p> <p>On 2/29/12 at 12:15 P.M., the 2 other units in the facility were observed to have all the bathroom and beside call bells functioning. At this time, the Administrator brought hand bells to residents on the West Unit and instructed them on use. The Administrator indicated the CNAs (certified nursing assistants) will do 15 minute checks on the residents to</p>		<p>day will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks. After that call lights checks will be conducted during daily maintenance building engines room checks conducted monthly or as needed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Random audits of 10 rooms per day will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks. After that call lights checks will be conducted during daily maintenance building engines room checks conducted monthly or as needed. This will be reviewed monthly during facility QA&A meeting for 3 months then quarterly times 3 months then as needed.</p> <p>Date the systemic changes will be completed: 4/6/12</p>				

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	<p>ensure their needs are being met. There were 17 residents on the west hall.</p> <p>On 2/29/2012 at 2:10 P.M. LPN #10 was interviewed. She indicated on the west unit all the call lights had been repaired and were functioning properly now.</p> <p>On 2/29/2012 at 2:15 P.M., the bathroom call lights in room 101, 107, 110 were rechecked and functioning.</p> <p>On 2/29/12 at 2:30 P.M., the Maintenance Man was interviewed. He indicated all the call lights had been fixed and were functioning properly.</p> <p>On 2/29/12 at 2:48 P.M., the bathroom call lights in rooms 101, 107 and 110 were rechecked and functioning.</p> <p>On 3/1/12 at 10:10 A.M. , the Maintenance Man was interviewed. He indicated on 2/29/12 at 2:30 P.M., all the bathroom and bedside call lights in the facility were working. He indicated the nursing staff had been doing 15 minute checks on the resident rooms but he wasn't sure how long these checks were done. He indicated the (name of the call</p>						

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	<p>light repair company) arrived at the facility today at 10 A.M.</p> <p>On 3/1/12 at 10:20 A.M., the Administrator was interviewed. She indicated yesterday at 4:30 P.M., the housekeeping manager, the maintenance man and herself had verified all the bathroom and beside call lights were functional. The Administrator indicated at this time, she was unaware of how long the 15 minute checks had been done.</p> <p>On 3/1/12 at 10:25 A.M., CNA #15 was interviewed. She indicated in addition to herself, LPN #10 and CNA #16 were working on the west hall unit today. CNA #15 indicated she had not checked any call lights today.</p> <p>On 3/1/12 at 10:27 A.M., LPN #10 was interviewed. She indicated she had not checked any call lights today.</p> <p>On 3/1/12 at 10:40 A.M., CNA #16 was interviewed. She indicated she did check 2 call lights in the bathrooms of rooms 110 and 104. She indicated these both were working. She indicated she checked the bathroom lights but wasn't sure why she did. She indicated no one told her to do this, she just did it</p>			
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	<p>automatically. She indicated she had checked the call lights by the beds to make sure they were in reach but did not check if they were functional.</p> <p>On 3/1/12 at 12 P.M., the DON (Director of Nursing) provided a current copy of the "One on One Visual Observation Documentation" form. This form indicated on 2/29/12 at 12:15 P.M. to 6 P.M., all the call lights on the West Unit were checked and working. This form also indicated there were call bells placed in all resident rooms at bedside and in bathrooms to ensure a form of notification of staff.</p> <p>On 3/1/12 at 12:31 P.M., the (name of the call light company) employees #1 and #2 were interviewed. They indicated they had replaced the call light in the bathrooms that weren't working properly. They indicated these were rooms 101, 107 and 110. They indicated everything was working properly now and the problem was a malfunction in the switches. They also indicated the call lights should be replaced if they don't work all the time.</p> <p>On 3/1/12 at 1:50 P.M., the Maintenance Man was interviewed. He indicated he checks the call lights</p>						

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	<p>in the residents' bedrooms and bathrooms once a month. He indicated the last time they had a problem with the call lights was last summer and he found this problem during his monthly checks. He indicated at that time, he thought the problem was a leak, so he caulked around the problem area. He indicated he had the (name of the call light repair company) in after the problem last summer. The Maintenance Man indicated he tested a call light and it didn't work properly even once, he would replace it.</p> <p>At 2:45 P.M. on 3/1/12, the Maintenance Man provided a copy of the service report from the call light repair company. This report indicated the call light systems had been replaced in rooms 107, 110 and 101 and everything was working properly at this time.</p> <p>On 3/2/12 at 11 A.M. the Maintenance Man was interviewed. He indicated last night the call light in room 127 and 129 were not functioning properly. He indicated the (name of call light repair company) was here currently working on the call lights. These rooms are located on the ACU unit.</p>						

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	<p>On 3/2/12 at 11:45 A.M., the Administrator was interviewed. She indicated since yesterday, they were doing the once a shift call light checks for call lights in each of the resident's bathroom and bedside. She indicated this morning with the 7:05 A.M., check, all the call lights were functioning appropriately. She indicated at 8:30 A.M., the call light in room 108 did not work, after having been checked 35 minutes prior. The Administrator indicated the (name of call light repair company) was checking all the call lights again. She indicated their once a shift call light check will continue until they are sure all the lights are working properly.</p> <p>On 3/2/12 at 1 P.M., the Administrator was interviewed. She indicated they would be doing more frequent call light checks than once a shift and she would make sure that all residents had bells at their bedside and also in every bathroom.</p> <p>On 3/5/12 at 9 A.M., the Administrator was interviewed. She indicated the facility was doing 24 hour monitoring for the call lights in the resident bathrooms and at bedside. They indicated they are physically going into each room and trying each call light as described above. She</p>			

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	<p>indicated it took her 3 hours to go to all the rooms in the facility. After the call light check is completed, she indicated all the residents are checked on. She stated all the residents have hand bells available at bedside and in their bathrooms. She indicated this process will continue until they are certain all the call lights are functional. She indicated they are currently in process of getting a new call light system approved. She indicated during the call light checking rounds on 3/3/12, they found a call light between 9 P.M. and 1 A.M. that wasn't working. This was a call light by the bedside in room 115.</p> <p>On 3/6/12 at 2 P.M., the Administrator was interviewed. She indicated there was a company currently in the building to replace the current call light system.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>				