

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2015
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NAME OF PROVIDER OR SUPPLIER  WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00163168.</p> <p>Complaint IN00163168-Substantiated. Federal/State deficiency related to the allegations is cited at F-463.</p> <p>Survey dates: January 20, 21, 22, 23, 26, 27 and 28th, 2015</p> <p>Facility number: 000158 Provider number: 155255 AIM number: 100291490</p> <p>Survey Team: Julie Call, RN, TC Sue Brooker, RD Martha Saull, RN Virginia Terveer, RN</p> <p>Census bed type: NF: 54 SNF: 27 NCC: 4 Total: 85</p> <p>Census payor type: Medicare: 7 Medicaid: 30</p>	F000000	This plan of correction is to serve as Woodview A Waters Community's allegation of compliance. Woodview A Waters Community is respectfully requesting a paper compliance	

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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F000279 SS=D	<p>Private: 48 Total: 85</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 3, 2015 by Randy Fry RN.</p> <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>			
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	<p>Based on observation, interview and record review, the facility failed to ensure a plan of care was developed for a resident with a Foley catheter (urinary catheter) for 1 of 1 resident's reviewed with a Foley catheter. (Resident #3)</p> <p>The facility also failed to develop a care plan for incontinence for 1 resident (Resident #1) of 2 residents who met the criteria for urinary incontinence.</p> <p>Findings include:</p> <p>1. On 1/23/15 at 11 a.m. the clinical record of Resident #3 was reviewed. A physician order dated 12/20/2012 included but was not limited to, the following: "Catheter type and size 18 fr (french)..." The TAR (treatment administration record) dated January 2015 included but was not limited to, the following physician order, dated 12/20/14: "...Catheter: change drainage bag..." Documentation was lacking of a care plan to address the Foley catheter.</p> <p>On 1/23/15 at 1:10 p.m. Resident #3 was observed sitting in her wheelchair (wc) at the table in the dining room. She was observed to have a Foley catheter bag positioned beneath her wc.</p> <p>On 1/26/15 at 9 a.m. Resident #3 was observed in her wc with the Foley</p>	F000279	F-279 It is the practice of Woodview, a Waters Community, to develop a comprehensive care plan for each resident that includes measurable objectives and time tables to meet a resident's medical, nursing mental and psychosocial needs that are identified in the comprehensive assessment. A plan of care has been developed to address the foley catheter in place for Resident which has since been discontinued and resolved for resident #3.(Exhibit 1) A plan of care has been developed to address the condition of incontinence for Resident #1.(Exhibit 2) Residents who reside in the facility and who have a foley catheter or who are incontinent of bowel/bladder have the potential to be affected by this finding. A facility wide audit has been completed to identify any residents who have either a foley catheter or whom are incontinent of bowel and/or bladder based on their most recent bowel and bladder assessments. These residents have had their care plans reviewed to be sure that their foley catheters and/or their incontinence of bowel and or bladder are comprehensively addressed on their care plans. The DON/Designee will monitor the 24 Hour Report Summary as well as the new orders daily at the CQI meetings. Any resident who has documentation related to a	02/27/2015			

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	<p>catheter bag positioned beneath the wc.</p> <p>On 1/26/15 at 11:15 a.m. the DON (Director of Nursing) provided a copy of the resident's current care plans. A care plan, which addressed the problem of "Wound present to anal cleft" had a "Revision on" date of 1/19/15. Interventions included but were not limited to, the following: F/C (Foley catheter) to be place (sic) to assist in wound healing, date initiated 1/26/15." The DON also provided the following care plan: " Has Dx (diagnosis) with need for Foley catheter, date initiated 1/26/15." Interventions included but were not limited to the following: "catheter care every shift and prn (as needed)...position tubing to facilitate tube draining during positioning and prn..."</p> <p>On 1/27/15 at 1:30 p.m. the DON provided a current copy of the facility policy and procedure for "Patient Care Policies/Overall Care Plan/Comprehensive Care Plan." This policy and procedure was undated. The policy included, but was not limited to, the following: "...purpose of this policy is:...provide and ensure a guide of each individual's needs; provide a means of communication for all personnel involved in the care of the resident; set realistic and measurable goals including</p>		<p>foley catheter or incontinence on any of these internal reports or new orders will have the care plan reviewed to see that it properly addresses these issues. Care plans will continue to be reviewed quarterly at the care plan meetings. An audit tool is being completed by the DON/Designee to review new orders and new admissions to see that foley catheters and/or incontinence is care planned timely. (Exhibit 3) At an inservice held for the nursing staff on 2/11/2015, the requirement to care plan the care and management of foley catheters and/or incontinence of bowel/bladder was reviewed. Any nursing staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. (Exhibit 4-1 &amp;4-2, A-D)</p> <p>The Quality Assurance committee will monitor monthly for at least six months, QA Committee will reevaluate if a need for continuation, any patterns observed with any foley catheters or incontinence not being properly care planned (when reviewed at the daily CQI meetings) will be addressed by an Action Plan written by the QA Committee.</p>	

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	<p>objectives and timetables...goals shall include medical, nursing and psychosocial need identified in the comprehensive admission assessment...The following aspects shall be addressed in the assessment of the residents needs: health...psychosocial status...A short term care plan will be initiated by a licensed nursing staff for any resident with an acute condition. A comprehensive care (sic) will be completed...within 7 days after completion of the MDS (minimum data set)...include at least the following:...resident's needs/problems; resident care priorities...If a residents needs or conditions change, a revision of the comprehensive care plan shall be completed as needed but at least quarterly will be reviewed.</p> <p>On 1/27/15 at 4:25 p.m. the ADON (Assistant Director of Nursing) provided a copy of the "Short term care plan." The care plan had a date of 10/27/14 and addressed the problem of "Open area to anal cleft..." Documentation was lacking regarding the Foley catheter. At the time, the ADON was interviewed. She indicated the short term care plan was kept in the "Alert Charting Book." The ADON indicated documentation was lacking in this book for a care plan for the resident which pertained to the Foley</p>			

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	<p>catheter.</p> <p>2. Review of the clinical record for Resident #1 on 1/23/15 at 10:37 a.m., indicated the following: diagnoses included, but were not limited to, dementia, history of traumatic brain injury, and other persistent mental disorder.</p> <p>Resident #1 was admitted to the facility on 11/10/14.</p> <p>During an observation on 1/20/15 at 3:26 p.m., Resident #1 was observed seated in his wheelchair in his room. There was a strong odor of incontinent stool surrounding the resident.</p> <p>A Bowel &amp; Bladder Incontinence Screener for Resident #1, dated 11/10/14, indicated he: did not always void appropriately without incontinence, but at least daily; was incontinent of stool daily; required the assistance of 2 staff to get to the bathroom/transfer to toilet/commode/urinal, adjust clothing and wipe; and was sometimes aware of the need to use the toilet.</p> <p>A Bladder Tracking record for Resident #1, dated for 11/12/14, 11/13/14, and 11/14/14, indicated he was incontinent 9 times on 11/12/14, 11 times on 11/13/14,</p>						

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	<p>and 3 times on 11/14/14. The tracking record did not include bowel tracking for continence/incontinence.</p> <p>A Minimum Data Set (MDS) assessment for Resident #1, dated 11/21/14, indicated a score of 10 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The MDS also indicated he required extensive assistance with the physical assistance of 2 staff for toileting. The MDS further indicated he was frequently incontinent of bowel and bladder.</p> <p>A Bowel Continence record for Resident #1 indicated he incontinent of stool on 1/13/15, 1/14/15, 1/15/15, 1/16/15, 1/18/15, 1/19/15, 1/20/15, 1/22/15, 1/23/15, 1/24/15, and 1/25/15.</p> <p>A Bladder Continence record for Resident #1 indicated he was incontinent of urine on 1/13/15, 1/14/15, 1/16/15, 1/17/15, 1/18/15, 1/19/15, 1/20/15, 1/21/15, 1/22/15, 1/23/15, 1/24/15. and 1/25/15.</p> <p>The DON was interviewed on 1/26/14 at 11:36 a.m. During the interview she indicated staff assigned to Resident #1 knew what care he required by a Kardex hanging on the inside of the door of the</p>			

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F000282 SS=D	<p>wardrobe in his room.</p> <p>A Kardex on the inside of the wardrobe door for Resident #1 was observed on 1/26/15 at 11:54 a.m. The Kardex indicated he required extensive assistance with the physical assistance of 1-2 staff for toileting. The Kardex did not indicate if he was on a toileting schedule or a check and change program.</p> <p>Certified Nursing Assistant (CNA) #9 was interviewed on 1/26/15 at 1:25 p.m. During the interview she indicated Resident #1 was frequently incontinent. When queried, she indicated he was currently not on any toileting schedule according to the Plan of Care kiosk.</p> <p>The ADON was interviewed on 1/27/15 at 8:42 a.m. During the interview she indicated a toileting schedule or a check and change schedule should be implemented for each resident after the 3 day voiding pattern was completed. She also indicated the facility had not developed a care plan for Resident #1 addressing his incontinence.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>						

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	<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, interview and record review, the facility failed to ensure physician orders were followed for application of a foot/ankle brace for 1 of 1 resident's reviewed with a prescribed foot/ankle brace. Resident #3</p> <p>Findings include:</p> <p>On 1/23/15 at 1:30 p.m. the clinical record of Resident #3 was reviewed. Diagnoses included, but were not limited to, the following: stroke, senile dementia.</p> <p>On 1/26/15 at 9 a.m. Resident #3 was observed in her wc (wheelchair) at the dining room table. No brace was observed to the resident's right leg at the time.</p> <p>On 1/26/15 at 11:51 a.m. the DON provided copies of the resident's current care plans. They included but were not limited to, the following: "(Resident's name) is at risk for skin breakdown due to decreased mobility...use of elastic stockings, use of right leg brace..." Date initiated: 5/16/14 and Revision on:</p>	F000282	F-282 It is the policy of Woodview, a Waters Community, to ensure that physician orders are followed for application of any ordered brace or splint per the physician's order. Resident #3, During survey on 1/27/15, therapy assessed resident for need of continuation of right foot splint, and wrote new orders to discontinue, care plan was resolved. (Exhibit 5 &6) An audit has been completed to identify any residents who have an order for a brace or splint. These devices have been reviewed by therapy to see that they are still appropriate. The "wear schedule" for these devices have also been reviewed. These devices are care planned and are being utilized as per physician's order. The DON/Designee will monitor residents who have braces or splints to see that they are being utilized as per order and care plan. This monitoring will occur weekly x 4 weeks then monthly thereafter. Any concerns will be addressed as discovered. (Exhibit 7) At the daily CQI meetings new orders for braces/splints will be addressed to see that they are carried out as per order. At that time they will be added to the DON/Designee's list of targeted residents with braces/splints to be	02/27/2015			

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	<p>5/22/14. Interventions included, but were not limited to, the following: "...Check skin under leg brace for redness or irritation every shift. Date initiated: 5/16/14..."</p> <p>On 1/26/15 at 12:18 p.m. the ADON provided copies of the resident's current physician orders. They included but were not limited to the following: "Brace to rt (right) lower leg on while up and off while in bed at bedtime...Document in Nurses notes every shift regarding rt leg brace and skin condition..." The original order had been dated 11/20/2010.</p> <p>On 1/26/15 at 12: 20 p.m. and at 1:20 p.m. the Resident was observed in her wc without a brace in place to her right leg.</p> <p>On 1/26/15 at 1:45 p.m. the CNA #19 was observed to transfer the resident with the supervision of LPN #7 from the resident's wc to her bed. CNA #19 removed the resident's shoes and put her bilateral heelbows (padded fabric type boots to prevent pressure sores) on. At the time, no brace was observed to have been in place to the resident's right leg/foot.</p> <p>On 1/26/15 at 4:50 p.m. Resident #3 was observed in the dining room in her wc with no brace in place to her right leg.</p>		<p>monitored per monitoring schedule. The Quality Assurance Committee will monitor monthly for at least six months and reevaluate if a need to continue, any patterns observed with any braces/splints will be addressed via an Action Plan written by the QA Committee.</p>	

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	<p>On 1/27/15 at 9 a.m. CNA #20 was interviewed. She indicated she was caring for Resident #3 today. She the resident wears the "boots" (heelbows) in bed but did not have a splint or brace that she was to wear on her leg/foot. She indicated if the resident did have a brace/splint that was to be worn, it would be either in the bathroom by the resident's ted hose, which are taken off every night, and/or in the top drawer of the bedside table. At this time, CNA #20 looked in the top drawer of the resident 's bedside table and there was not a splint/brace located. At the time, she also looked in the resident's closet and was unable to find a splint/brace in there.</p> <p>On 1/27/15 at 9:04 a.m. LPN #21 entered Resident #3's room. She indicated she was caring for the resident at the time. LPN #21 indicated the last time she knew Resident #3 did have a right hand and right lower extremity device but she wasn't sure when this order began. At the time, the ADON (Assistant Director of Nursing) was interviewed. She indicated the resident was to have a right hand splint applied at bedtime and taken off in the morning. The ADON also indicated the resident was to have had a brace on her right leg/foot while she was up. At the time, Resident #3 was observed in the</p>			

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	<p>dining room in her wheelchair without a brace on to her right leg. At the time, LPN #21 and the ADON were observed to go into the resident's room. LPN #21 was looking for the resident's leg brace in the resident's closet. After digging around in the closet, she pulled out a long gray leg immobilizer type device, which would extend from the resident's ankle to up over the knee to the mid thigh. LPN #21 showed this immobilizer to the ADON and the ADON indicated "No, that's not it." The ADON was observed to look in the resident's bedside table and after digging around in the drawers, found the leg brace in the bottom drawer. The device the ADON removed from the resident's bottom drawer of the bedside table was a piece of plastic that the resident's foot would be placed in. The plastic would extend on the bottom of the resident's foot, covered the heel and extended up the back of the resident's leg. The ADON indicated the foot/ankle brace was used when the resident ambulated but the ADON indicated the resident didn't ambulate anymore. The ADON indicated at this time, they had put in a referral to see if the resident still needed the foot brace/splint device.</p> <p>On 1/27/15 at 10 a.m. the Administrator provided a current copy of the resident's Treatment Administration Record (TAR).</p>			
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F000323 SS=E	<p>The following orders were observed on this form: "Check skin condition rt (right) lower leg for open area every shift d/t (due to) brace worn daily...Brace to rt lower leg on while up and off while in bed at bedtime..." Both of these orders had a start date of 9/1/2011. Both of these orders were documented on the TAR as having been completed for all three shifts on 1/26/15.</p> <p>On 1/28/15 at 10:59 a.m. the Nurse Consultant was interviewed. She indicated the facility doesn't have a policy and procedure regarding following physician orders as this would just be "part of the Nurse Practice Act, just part of what the nurse does."</p> <p>3.1-35(g)(2)</p> <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. Based on observation, interview and record review the facility failed to ensure safe water temperatures for 3 of 35 rooms (Rooms 30, 32, and 34) on 1 of the 5 facility's units (North Hall) observed for hot water temperatures, potentially</p>	F000323	F-323 It is the practice of Woodview, a Waters Community, to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and	02/27/2015

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	<p>effecting 4 residents. (Resident #24, #64, #82, and #113)</p> <p>Findings include:</p> <p>1. During an observation of Resident #113's and #82's room #34 on 1/21/15 at 1:59 p.m., the hot water in the bathroom's sink was hot to touch and the water steamed when it came out of the faucet. The water temperature measured 131.1 degrees F (Fahrenheit).</p> <p>An Interview with Resident #113 on 1/21/15 at 2:00 p.m., indicated she can add cold water to regulate the temperature if it was too hot.</p> <p>An observation on 1/21/15 at 2:10 p.m. of Resident # 24's room #32, indicated the hot water temperature in the bathroom sink measured 129.6 degrees F.</p> <p>On 1/21/14 at 2:30 p.m., the list of Facility's residents identified as alert and oriented, provided by the Facility on 1/20/15 at 3:30 p.m. indicated the following:</p> <ul style="list-style-type: none"> <li>-Resident #113 was alert and oriented</li> <li>-Resident # 82 was not alert or oriented.</li> <li>-Resident #24 was not alert or oriented</li> <li>-Resident #64 was not alert or oriented.</li> </ul>		<p>assistance to prevent accidents. Currently, all resident rooms have water temperatures that are safe and within accepted parameters of state/federal regulations. The plumber's work repaired all areas cited. All those who use water in resident rooms or in bathing/toileting areas have the potential to be affected by the finding. The Maintenance staff will monitor water temps in these areas, 3 rooms in each hall weekly. The temps will be part of the Preventive Maintenance program and will be documented. Any concerns will be addressed immediately upon discovery. The source of the water in question will be immediately shut off until repaired. (Exhibit 8) At an all staff inservice held February 11, 2015, (Exhibit 9 A-C) the water temperature monitoring process will be reviewed. Staff will be reminded as to what they need to do if they feel water temps are too warm or too cool. Additionally, staff will be reminded as to what they need to do if a resident or family member questions the water temperature in a resident room or bathing or toileting area.</p> <p>At the daily CQI meetings any concerns with water temps and what was done immediately upon discovery will be addressed. The Administrator will monitor the preventive Maintenance Logs weekly for 4 weeks. The Quality Assurance Committee will monitor for at least six months</p>		

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	<p>On 1/21/14 at 3:30 p.m., Review of the Residents' current MDS for their BIMS score, Transfer ability and mobility in the facility indicated the following:</p> <p>-Resident #113's MDS (Minimum Date Set) dated 11/9/14 indicated the Resident's BIMS (Brief Interview for Mental Status) score was 15, which indicated she was cognitively intact. The MDS further indicated Resident #113 required extensive assistance of 1 person to physically assist resident to transfer and also indicated she was independent in mobility on the unit with a mobility devices of a wheelchair or a walker.</p> <p>-Resident #82's MDS dated 11/11/14 indicated resident was rarely understood, with no BIMS score. The MDS further indicated Resident #82 required extensive assistance of 1 person to physically assist resident to transfer and also indicated she required assist of 1 person to physically assist he with mobility on the unit with a mobility device of a wheelchair.</p> <p>-Resident # 24's MDS dated 12/1/14 indicated the Resident's BIMS score was 01, which indicated severe cognitive impairment. The MDS further indicated Resident #24 required extensive</p>		and reevaluate if a need to continue.	

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	<p>assistance of 2 persons to physically assist resident to transfer and also indicated she required assist of 1 person to physically assist her with mobility on the unit with a mobility device of a wheelchair.</p> <p>-Resident # 64's MDS dated 11/4/14 indicated the Resident's BIMS score was 03 which indicated severe cognitive impairment. The MDS further indicate Resident #64 required extensive assistance of 2 persons to physically assist resident to transfer and also indicated she required assist of 1 person to physically assist her with mobility on the unit with a mobility device of a wheelchair.</p> <p>2. Observations of the North Hall's water temperatures on 11/21/15 indicated the following:</p> <p>-At 4:40 p.m., in room 30, the hot water to the bathroom sink was turned off and a sign was posted on the mirror above the sink. The sign stated, "Please Do Not use sink in bathroom to wash hands until further notice."</p> <p>-At 4:25 p.m., in room 32, the hot water to the bathroom sink was turned off and a sign was posted on the mirror above the</p>			

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	<p>sink. The sign stated, "Please Do Not use sink in bathroom to wash hands until further notice."</p> <p>-At 4:30 p.m., in room 34, the hot water to the bathroom sink was turned off and a sign was posted on the mirror above the sink. The sign stated, "Please Do Not use sink in bathroom to wash hands until further notice."</p> <p>An interview with Resident #113 on 11/21/15 at 4:30 p.m., indicated Maintenance turned the hot water off and a plumber is checking for the problem with the hot water.</p> <p>3. Observations of Rooms 30, 32, and 34 on the North Hall on 11/22/15 at 3:50 p.m., indicated the hot water remained turned off in the bathroom sinks and the signs remained posted on the mirror. The sign stated, "Please Do Not use sink in bathroom to wash hands until further notice."</p> <p>An interview with the Administrator, on 1/22/15 at 4:00 p.m., indicated the hot water remained turned off in the rooms on the east side of the hall. She indicated the Resident's families were notified of the problem with the hot water and the hot water would remain off until it was fixed. The Administrator indicated the</p>						

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	<p>families were in agreement. She further indicated the plumber was at the facility yesterday and he indicated for the older plumbing in the North Hall, they would need to install individual water mixing valves at each of the effected rooms' bathroom sinks. She also indicated the water mixing valves were ordered and would arrive tomorrow morning and the plumber will install them tomorrow afternoon. The Administrator indicated the hot water to the effected rooms would remain shut off until repaired. She indicated the entire facility's hot water temperatures continued to be monitored.</p> <p>4. An observation on 1/23/15 at 9:00 a.m., of rooms 30, 32, and 34 on the North Hall indicated the hot water remained turned off and the sign remained posted on the mirror.</p> <p>An interview on 1/23/15 at 9:00 a.m., with Resident #113, indicated the hot water was supposed to be repaired in the afternoon.</p> <p>An interview on 1/23/15 at 9:30 a.m., with the Administrator indicated the plumbing parts were to arrive today and the plumber was scheduled in the afternoon. She indicated the hot water temperatures were being monitored in the entire building.</p>			

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	<p>An interview on 1/23/15 at 11:15 a.m., with the Maintenance Manager (MM), indicated the plumbers were at the facility to install the water mixing valves in 6 rooms on the North Hall.</p> <p>An interview on 1/23/15 at 3:15 p.m., with the Administrator, indicated the plumbers finished installing the mixing valves in the rooms. She indicated the hot water temperatures will be monitored in the entire facility daily for the following week.</p> <p>An interview on 1/26/15 at 3:45 p.m., with the Administrator indicated the hot water temperature should range from 100 to 120 degrees. She indicated the Facility had 3 more individual mixing valves to have on hand if there were any problems with hot water temperatures being too hot in other rooms.</p> <p>An interview with MM on 1/27/15 at 12:15 p.m., indicated the plumber had to come back to the facility earlier today to change the main mixing valve in the facility. He indicated they also have additional mixing valves for rooms ordered to have on hand if needed.</p> <p>Review of the Facility's policy, provided by the Administrator on 1/26/15 at 4:56,</p>			

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	<p>titled, Indiana Administrative Code, indicated the following, "...(r) The hot water temperature for all bathing and hand washing facilities shall be controlled by automatic control valves. The water temperatures at the point of use must be maintained between: (1) one hundred (100) degrees Fahrenheit; and (2) one hundred twenty (120) degrees Fahrenheit....)</p> <p>5. On 1/21/15 at 2:56 p.m. the water temperature in room 34 was checked with the MM's (Maintenance Manager) thermometer. The MM read the water temperature in the resident's bathroom at 133 F (Fahrenheit). He indicated he could see the steam coming off the water as it came out of the faucet. He indicated he had never seen the water temperature "that high." He indicated he had just turned the temperature valve down last week because they were getting water temperatures of 118-119 F and he wanted the water temperatures lower than that.</p> <p>On 1/21/15 at 2:57 p.m. the MM was interviewed. He indicated his Assistant checked the water temperatures once a week by randomly performing water checks in the facility. He indicated the Assistant tested water temperatures in 3 rooms per hall. The MM indicated the water temperatures were checked earlier today and were fine. The MM indicated</p>			

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F000329 SS=D	<p>his goal for the water temperatures would be at 110-115 F.</p> <p>On 1/21/15 at 3 p.m. the water temperatures in the following rooms were obtained by the MM (maintenance man) with his thermometer used: the bathroom in Rm 30 had a water temperature of 132.8 F.</p> <p>3.1-45(a)(1)</p> <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>			

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	<p>Based on interview and record review the facility failed to provide clinical rationale for the increase of a psychotropic medication for 1 of 5 residents (Resident #73) who met the criteria for unnecessary medication.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #73 on 1/22/15 at 11:06 a.m., indicated the following: diagnoses included, but were not limited to, chronic pain syndrome, diabetes mellitus, hypertension, congestive heart failure, epilepsy, and panic disorder without agoraphobia (avoidance of places or situations).</p> <p>A physician report for Resident #73, dated 4/4/14, indicated she was referred to the Neurologist for an evaluation of her neck pain. The cerebellar examination showed bilateral intention tremors. The Neurologist did not indicate a diagnosis of epilepsy.</p> <p>A Social Services Progress Note for Resident #73, dated 5/22/14, indicated she received Cymbalta 60 mg (milligrams) daily for depression and Clonazepam 0.5 mg BID (twice a day) PRN (as needed) for panic disorder</p>	F000329	<p>F-329 It is the practice of Woodview, a Waters Community, to ensure that residents who have not used antipsychotics are not given these drugs unless antipsychotic therapy is necessary to treat a specific condition or diagnosed and documented in the clinical record Further, residents who receive antipsychotic drugs will be on a gradual dose reduction plan with behavioral interventions in an effort to discontinue these drugs unless clinically contraindicated A facility wide audit was conducted and any resident who was receiving medication for behaviors or depression had the diagnosis for the medication verified. Resident # 73 was seen by the Psych professional on 2/20/15, No medication changes at this time, Resident's dosing schedule will have a re evaluation in 30 days, per psych professional recommendations The DON/Designee will audit daily at the CQI meetings any new orders for meds for behaviors to verify unacceptable supporting diagnosis. Further, weekly at these meetings, prn meds used for behaviors will be reviewed for supporting documentation. Held an in-service on 2/17/15, (exhibit 10 A-B) the requirement for medication used for behavior management were reviewed this included A- Definition of behavior management</p>	02/27/2015			

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	<p>without agoraphobia. The note also indicated she had requested/received the PRN Clonazepam 7 times during the 7-day assessment period. The note further indicated the DON submitted a request for a gradual dose reduction (GDR) to the Nurse Practitioner (NP) on 2/24/14. The NP did not recommend a GDR in her Cymbalta and Clonazepam due to the resident being stable. During the 7-day assessment period, no delusions, hallucinations or behaviors were documented. The note indicated Resident #73 could be extremely manipulative at times and attention seeking.</p> <p>The Medication Administration Record (MAR) for Resident #73, dated for the month of May 2014, indicated she requested and received the PRN Clonazepam 32 times. The MAR did not indicate what behaviors or changes in mood the resident was experiencing when requesting the PRN medication.</p> <p>An Administration Documentation History Detail Report for Resident #73, dated for the month of May 2014 did not indicate she displayed any behaviors or changes in mood.</p> <p>A MAR for Resident #73, dated for the month of June 2014, indicated she</p>		<p>B-Diagnosis-acceptable/ supporting C-Non-pharmacological/pharmacological interventions D- GDR/Avoidance unnessasary drugs E- Required documentation/ care planning Staff who fail to comply with the points of the in-service will have further education and/or progressively discipline as indicated. The Quality Assurance Committee will monitor for at least six months and reevaluate if a need to continue,the result of the daily and weekly monitoring done by the DON/Designee will be reviewed for any patterns. If necessary,an Action Plan will be written by the QA Committee.</p>		

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	<p>requested and received PRN Clonazepam 29 times. The MAR did not indicate what behaviors or changes in mood the resident was experiencing when requesting the PRN medication.</p> <p>A MAR for Resident #73, dated for the month of July 2014, indicated she requested and received PRN Clonazepam 6 times. The MAR did not indicate what behaviors or changes in mood the resident was experiencing when requesting the PRN medication.</p> <p>A Progress Note for Resident #73, dated 7/5/14 and written by the NP, indicated she was experiencing seizure activity the previous evening per resident report. The note also indicated staff reported she was cognitive of her surroundings and actually requested pain and anxiety medications during the time she declared she had seizure activity. The note further indicated Resident #73 requested PRN Clonazepam on a regular basis. The note also indicated Resident #73 was not on any seizure medications.</p> <p>A physician's order for Resident #73, dated 7/5/14, indicated to discontinue PRN Clonazepam. The order also indicated to start Clonazepam 0.5 mg BID.</p>			

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	<p>An Antianxiety Use Notification for Resident #73, dated 7/14/14, indicated she was requesting Clonazepam 0.5 mg BID due to complaints of seizure activity. The notification also indicated there were no signs/symptoms of post seizure activity.</p> <p>A Request for Gradual Dosage Reduction for Resident #73, dated 8/11/14, indicated she received Cymbalta 60 mg daily and Clonazepam BID for depression and panic disorder. The request also indicated the physician did not recommend any changes in medication.</p> <p>A Social Service Progress Note for Resident #73, dated 8/18/14, indicated she received Cymbalta 0.5 mg daily for depression and Clonazepam 0.5 mg BID for panic disorder without agoraphobia. The note also indicated the Clonazepam was changed from 0.5 mg BID PRN to 0.5 mg BID by the Nurse Practitioner at the resident's request due to "seizure activity." The note further indicated the DON submitted a request for a GDR to the Nurse Practitioner on 8/11/14. The Nurse Practitioner did not recommend a GDR in her Cymbalta and Clonazepam due to the resident being stable. During the 7-day assessment period, no delusions, hallucinations or behaviors</p>			

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	<p>were documented. The note indicated Resident #73 could be extremely manipulative at times and attention seeking.</p> <p>An Administration Documentation History Detail Report for Resident #73, dated for the month of August 2014 did not indicate she displayed any behaviors or changes in mood.</p> <p>Review of the Resident Progress Notes for Resident #73, dated 5/5/14 through 7/5/14, did not indicate she had experienced any panic attacks or seizures.</p> <p>Physician orders for Resident #73, dated for the month of January 2015 indicated she received Cymbalta 0.5 mg daily for depression and Clonazepam 0.5 mg BID for panic disorder without agoraphobia.</p> <p>Social Service and the DON were interviewed on 1/26/15 at 4:02 p.m. During the interview they indicated nursing staff had not documented any reason for the PRN Clonazepam prior to giving the medication to Resident #73.</p> <p>The DON was interviewed on 1/27/15 at 10:13 a.m. During the interview she indicated the facility policy on psychotropic medication did not discuss the addition or increase of psychotropic</p>			

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	<p>medications.</p> <p>A facility care plan for Resident #73, with a review date of 11/22/14, indicated the focus area of diagnoses of depression, panic disorder without agoraphobia, insomnia, attention seeking, overly dramatic, impatient with staff, exhibited manipulative behavior, and difficulty with boundaries. Currently receives Cymbalta as ordered for depression and Clonazepam as ordered for panic disorder without agoraphobia. Interventions to the problem included, but were not limited to, document any behaviors of manipulation that occur and any moods/behaviors that occur which are stressful, encourage resident to stay up during the day to promote sleep at night, encourage verbalization of feelings and fears through active listening, give medication as ordered, observe for adverse effects, may be seen by psychologist, and dose reduction request to be made per facility policy.</p> <p>A facility care plan for Resident #73, with a review date of 11/22/14, indicated the focus area of resident has a diagnosis of panic disorder without agoraphobia and depression. Interventions to the focus included, but were not limited to, may be seen by psychologist, medication review, medication adjustment, and</p>				

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F000332 SS=D	<p>medication monitoring.</p> <p>A current facility policy "Tapering of a Medication Dose/Gradual Dose Reduction (GDR)" from the Woodview Health Policy Manual, dated 12/14/14 and provided by the DON on 1/26/15 at 4:53 p.m., indicated "...When evaluating the resident's progress, the practitioner reviews the total plan of care, orders, the resident's response to medication(s), and determines whether to continue, modify, or stop a medication:..."</p> <p>3.1-48(a)(4)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure the medication administration rate did not exceed 5% for 3 of 26 medication administration opportunities observed, which resulted in an error rate of 11.5%. (Resident #114, 68 and 76)</p> <p>Findings include:</p> <p>1. An observation of the medication pass</p>	F000332	F332 It is the practice of Woodview, A Waters Community to ensure that it is free of medication error rates of 5% or greater. Resident #114 was not affected by the deficient practice. Resident 114 and all other residents' medication orders were reviewed to ensure correct administration of medications with food. If order indicates to be administered with food, Nurse is required to administer with food. To ensure meds requiring administration with food are being administered with food, the	02/27/2015

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	<p>for Resident #114 on 1-22-2015 at 3:42 p.m., indicated LPN #5 administered metformin (an oral antidiabetic medication) 850 mg (milligram) tablet by mouth without food. Resident #114 was observed to eat her evening meal in the main dining room which was served after 5:00 p.m. on 1-22-2015.</p> <p>A review of the most recent physician's recapitulation provided on 1-26-2015 at 12:17 p.m. by the Director of Nursing (DON), indicated the order as "metformin 850 mg tablet give 1 tablet by oral route 2 times per day with morning and evening meals."</p> <p>2. An observation of the medication pass on 1-22-2015 at 4:37 p.m. (the actual time of the injection), indicated LPN #5 administered a Humalog injection (a fast acting insulin) of 17 units subcutaneously to Resident #68. Further observation indicated Resident #68 was not served her evening meal until 5:15 p.m. in the South dining room.</p> <p>3. An observation of the medication pass on 1-22-2015 at 4:44 p.m. (the actual time of the injection), indicated LPN #5 administered a Humalog (a fast acting insulin) flexpen injection of 10 units subcutaneously to Resident #76. Further observation indicated Resident</p>		<p>Director of Nursing will randomly observe Medication administration at least 2x weekly, and observe "serve with food orders" for Nurse compliance and report to Quality Assurance Committee. The Director of Nursing will document observations on med pass audit form. All Nurses will be in-serviced on ensuring if medications need to be administered with meals that medications are administered with meals. The Quality Assurance Committee will oversee the facility for compliance, on a monthly basis, at a minimum of 6 months, and continue thereafter as needed. Resident #68 and #76 receive fast-acting insulin and will receive their meal within 15 minutes of administration. An audit has been completed of all residents who receive fast-acting insulin, and while no residents had adverse reaction, they all had potential to be affected. For all residents who receive fast-acting insulin facility will make every attempt to serve meal within 15 minutes of insulin administration. . All nurses will be in-serviced regarding manufacturer's-guidelines to have meal within 15 minutes of insulin administration. All nurses will be required to ensure when-fast-acting insulin is administered, they make every effort to ensure the resident-is</p>	

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	<p>#76 was not served her evening meal until 5:10 p.m. in the South dining room.</p> <p>An interview with LPN #2 on 1-22-2015 at 4:10 p.m., indicated Humalog insulin injections should not be administered more than 30 minutes before meals.</p> <p>An interview with the Director of Nursing (DON) on 1-26-2015 at 9:45 a.m., indicated residents who received Humalog should get their meal/snack within 15 minutes of the fast acting insulin injection. Further interview with the DON indicated, a resident with an order to give a medication with a meal, should have the medication no earlier than 30 minutes prior to a meal.</p> <p>A policy "Insulin Injection Administration Procedure" last updated June 19, 2012 and provided by the DON on 1-26-2015 at 9:01 a.m. indicated the "...onset of action...Humalog...5 min (minutes) - 15 min...."</p> <p>A Humalog package insert copy dated 11/2013 and provided by the Administrator on 1-26-2015 at 12:30 p.m., indicated under "...Dosage and Administration...administer within 15 minutes before a meal or immediately after a meal...."</p>		<p>served a meal within 15 minutes. To ensure meal service offered within 15 minutes, the nurse will be responsible for utilizing the "Fast Acting Insulin/meal Delivery-Audit", at each meal, and document the time fast acting insulin administered-and the time meal was offered/served. New orders of fast acting insulin will be discussed at the daily-CQI (Continuous Quality Improvement) meetings and added to audits. The Director of Nursing/Designee will be-responsible for collecting the audits and checking Nurse compliance, with-Fast-acting insulin administration and 15 minute meal service. The Director of Nursing will bring all audits and reports of compliance to the Quality Assurance Committee, who will-oversee facility compliance, monthly, for at least 6 months, and continue there after as needed</p>	

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F000371 SS=E	<p>3.1-25(b)(9)</p> <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 staff failed to wash their hands appropriately and for the recommended time and after touching a soiled item and sneezing in the main dining room, the South dining room, and the Skilled dining room potentially affecting 84 of 85 residents who ate meals prepared by the facility. The facility also failed to ensure food was served at the recommended temperature, failed to protect food from contamination, failed to clean a thermometer with an alcohol wipe while checking food temperatures, and failed to provide food from an approved source in the Skilled dining room potentially affecting 22 of 22 residents residing in the Skilled Unit.</p> <p>Findings include:</p> <p>1. During an observation of the lunch</p>	F000371	F-371 It is the practice of Woodview, a Waters Community, to ensure that food is served in a sanitary and safe manner. Currently, staff practice proper hand hygiene as food trays are delivered and set up for the residents. Food is served at acceptable temps as per state/federal guidelines. Food is secured from approved vendors/sources acceptable bystate/federal guidelines. Food is kept covered to avoid contamination prior to being served to residents. Residents who receive food from the facility's dietary department or who attend facility sponsored meals have the potential to be affected by this finding. The DON/Designee will observe 5 meal services ( at various times) weekly x 4 weeks then randomly meals monthly there after for 3 months, to ensure compliance to observe for proper hand hygiene by state/federal guidelines. Food remaining covered and protected from	02/27/2015			

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	<p>meal on 1/20/15 in the main dining room, the following was observed:</p> <ul style="list-style-type: none"> <li>- At 12:10 p.m. Certified Nursing Assistant (CNA) #9 was observed to enter the dining room. She was observed to lather her hands for 14 seconds prior to rinsing. She was then observed to prepare a cup of coffee for a resident seated at a table in the dining room.</li> <li>- At 12:15 p.m., CNA #9 was observed to lather her hands for 11 seconds prior to rinsing. She then began meal service to residents.</li> <li>- At 12:25 p.m., CNA #9 was observed to lather her hands for 9 seconds prior to rinsing. She then resumed meal service to residents.</li> <li>- At 12:35 p.m., CNA #14 was observed to enter the dining room. She was observed to lather her hands for 12 seconds prior to rinsing. She was then observed to assist with meal service.</li> <li>- At 12:40 p.m., CNA #9 was observed to lather her hands for 7 seconds prior to rinsing. She then resumed meal service to residents.</li> <li>- At 12:45 p.m., CNA #14 was observed to lather her hands for 9 seconds prior to</li> </ul>		<p>contamination will also be observed at these times. Any concerns will be corrected immediately when observed. The facility has since stopped the practice of having a "carry in" Instead any families or staff desiring to have a "special event meal", will request from the Dietary Manager, to provide and prepare any "special event" (Exhibit 17) Staff will be educated on this practice of "special event meals" Training will be completed by 2/26/15 At an inservice held for all staff on February 11, 2015, food handling safety was reviewed. This included: a. Hand Hygiene b. Covering food c. Delivery of food d. Required temps At an in-service held for dietary staff on February 11, 2015, food handling safety was reviewed. This included: (Exhibit 11 A-N) a. Food handling-Hand Hygiene b. Food storage c. Food safety d. Food temps Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. The Quality Assurance Committee will monitor monthly for at least six months then reevaluate if a need to continue, the results of the monitorings will be discussed. However, any concerns will have been corrected at the time of discovery by the staff doing the monitorings.</p>		

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	<p>rinsing. She was then observed to serve a grilled cheese sandwich to a resident seated at a table in the dining room.</p> <p>- At 12:17 p.m., LPN #10 and CNA #9 were observed to reposition a resident in her wheelchair. After repositioning the resident and moving her wheelchair into place at the dining room table, LPN #10 was observed to lather her hands for 16 seconds prior to rinsing. She then resumed meal service to residents. CNA #9 was observed to lather her hands for 9 seconds prior to rinsing. She then resumed meal service to residents.</p> <p>2. During an observation of the lunch meal on 1/22/15 in the South Unit dining room, the following was observed:</p> <p>- At 11:56 a.m., LPN #11 was observed to lather her hands for 7 seconds prior to rinsing. She was then observed to place clean clothing protectors on residents seated at the dining tables.</p> <p>- At 12:00 p.m., LPN #11 was observed to lather her hands for 4 seconds prior to rinsing. She was then observed to pass meal trays to residents.</p> <p>- A 12:07 p.m., LPN #11 was observed to lather her hands for 10 seconds prior to rinsing. She then resumed passing meal</p>			

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	<p>trays.</p> <p>- At 12:11 p.m., CNA #12 coughed into her sleeve. She continued to prepare a meal tray for a resident without washing her hands.</p> <p>3. During an observation of the lunch meal 1/22/15 in the Skilled Unit dining room, the following was observed:</p> <p>- At 12:15 p.m., CNA #1 was observed to lather her hands for 10 seconds prior to rinsing. She was then observed to pass meal trays to residents.</p> <p>- At 12:20 p.m., Activities #8 was observed to wash her hands for the recommended amount of time, but lathered her hands under running water the entire time. She was then observed to assist with meal service to residents.</p> <p>- At 12:22 p.m., CNA #1 was observed to lather her hands for 8 seconds prior to rinsing. She was then observed to pass meal service to residents.</p> <p>4. During an observation of the Skilled Unit on 1/23/15, the following was observed:</p> <p>- At 10:10 a.m., 2 Crock pots, containing chili and chicken taco soup were plugged</p>				

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	<p>into an electrical outlet on the counter in the Diet Kitchen. When queried, LPN #6 and CNA #1 indicated it was national soup and dessert month. They also indicated staff and family had brought in homemade soups and desserts to share with the residents, family, and staff. They further indicated they did something similar each month for the residents, family, and staff in the Skilled Unit.</p> <p>- At 10:20 a.m., a large clear plastic bin, containing potato soup, was observed on the counter in the kitchenette area. The soup was not in a Crock pot to ensure it was kept at the recommended temperature. Also on the counter was a strawberry pie with whipped topping. The pie was not in the refrigerator to ensure it was kept at the recommended temperature.</p> <p>- At 10:59 a.m., the majority of the potato soup had been placed into a Crock pot plugged into an electrical outlet on the counter in the kitchenette area. Also on the counter were 2 chocolate cream pies with whipped topping as well as the same strawberry pie with whipped topping. The pies were not in the refrigerator to ensure they were kept at the recommended temperature. Activities #13 was observed to bring a cake to the kitchenette. An unidentified staff</p>						

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	<p>member was observed to being a cherry pie to the kitchenette.</p> <p>- At 11:16 a.m., Activities #8 was observed to lather her hands for 16 seconds prior to rinsing. She was then observed to assist with meal service.</p> <p>- At 11:35 a.m., CNA #1 took the temperatures of the chili and the chicken taco soup at the request of the surveyor. Prior to taking the temperatures she was observed to lather her hands for 11 seconds prior to rinsing. She was not wearing her glasses and indicated to the surveyor she could not read the dial of the thermometer. After taking the temperature of the chili, she wiped the probe of the thermometer with a paper towel and proceeded to take the temperature of the chicken taco soup. The temperatures of the potato soup and zuppa soup, which had been brought to the kitchenette in a Crock pot by the DON, were taken. The temperatures of the chili, chicken taco soup, and zuppa soup were within the recommended range. The temperature of the potato soup was 130 degrees.</p> <p>- At 11:38 a.m., the 2 Crock pots which had been plugged into an electrical outlet in the Diet Kitchen were moved to the counter in the kitchenette. There were</p>			

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	<p>not plugged into an electrical outlet on the counter in the kitchenette to ensure they maintained the recommended temperature. The Crock pot of the zuppa soup was not plugged into an electrical outlet as well. A folding table perpendicular to the counter had been set up to hold the desserts. The desserts were immediately next to the area where the staff obtained bowls of soup to serve to the residents.</p> <p>- At 11:39 a.m., a bowl of potato soup was served to a resident. The temperature of the soup had not been re-taken to ensure the soup was within the recommended range.</p> <p>- At 11:40 a.m., a facility volunteer brought a homemade chocolate cream pie with whipped topping, a peach cream pie, and an apple pie. The pies were placed uncovered on the table with the other desserts.</p> <p>- At 11:46 a.m., the Administrator was observed to wash her hands for 11 seconds. She was observed to lather her hands under the running water for the entire time.</p> <p>- At 11:47 a.m., Activities #8 was observed to lather her hands for 12 seconds prior to rinsing. She was then</p>			

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	<p>observed to resume meal service to residents.</p> <p>- At 11:51 a.m., the facility volunteer was observed to lather her hands for 8 seconds prior to rinsing. She was then observed to resume meal service to residents.</p> <p>- At 11:53 a.m., Activities #8 was observed to lather her hands for the appropriate amount of time, but lathered her hands under running water the entire time. She was then observed to resume meal service to residents.</p> <p>- At 12:02 p.m., 17 of the 19 residents present in the Skilled Unit dining room had received bowls of soup. Five residents had received bowls of potato soup.</p> <p>- At 1:05 p.m., no servings had been cut from 2 of the desserts on the folding table.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 1/27/15 at 10:30 a.m. During the interview he indicated staff were to lather their hands for 20 seconds before rinsing and were to wash their hands after touching a soiled object or coughing. He also indicated food should be kept and served at the appropriate</p>			

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	<p>temperature and protected from contamination. He further indicated residents were to receive food purchased from an approved vendor.</p> <p>The CDM was interviewed on 1/27/15 at 1:25 p.m. During the interview he indicated an alcohol wipe was to be used when cleaning the probe of a food thermometer.</p> <p>A current undated facility policy "Food Temperatures", provided by the CDM on 1/27/15 at 11:27 a.m., indicated "...1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F (Fahrenheit)...2. All cold food items must be maintained and served at a temperature of 41 degrees F or below...6. Foods prepared during special events...will be handled using the same safe temperature guidelines as all other foods...."</p> <p>5. During an observation of the lunch meal on 1/20/15 in the South dining room the following was observed:</p> <p>- At 11:55 a.m., LPN (Licensed Practical Nurse) #11 was observed to wash her hands with soap and water; she lathered her hands for 10 seconds before rinsing her hands with water. She dried her</p>			

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	<p>hands with a paper towel, then served a meal tray to a Resident seated at the table.</p> <p>-At 11:56 a.m., LPN #7 was observed to wash her hands with soap and water; she lathered her hands for 12 seconds before rinsing her hands with water and dried her hands with a paper towel, then served a meal tray to a Resident seated at the table.</p> <p>-At 11:58, CNA #33 was observed to wash her hands with soap and water; she lathered her hands for 15 seconds before rinsing with water and drying her hands with a paper towel then sat down to assist a Resident eat their meal.</p> <p>-At 12:00 p.m., LPN #7 was observed to cut a Resident's food with a fork and knife then washed her hands with soap and water; she lathered her hands for 5 seconds before rinsing her hands with water and dried her hands with a paper towel.</p> <p>-At 12:05 p.m., LPN #11, was observed to wash her hands with soap and water; she lathered her hands for 15 seconds then rinsed her hands with water and dried her hands with a paper towel. She delivered a meal tray to a Resident seated at a table and assisted to prepare their</p>			

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	<p>food.</p> <p>-At 12:10 p.m., LPN #11, was observed to wash her hands with soap and water, she lathered her hands, moving her hands in and out of the water during lathering and rinsed her hands with water and dried her hands, taking 15 seconds to wash and dry her hands.</p> <p>6. During an observation of the noon meal service in the skilled unit on 1-20-2015, the following was observed:</p> <p>-at 12:21 p.m., CNA #1 delivered a lunch tray to room 102 by walking through a common hallway around the dining area and nurse station with the dome not completely covering the food on the plate.</p> <p>-at 12:22 p.m., CNA #17 moved a resident by placing her hands on the wheelchair handles and pushed the wheelchair from the table to another table. CNA #17 moved a trash can in order to get the wheelchair through the space. CNA #17 was observed to pick up the resident's lunch dishes and carried them to her new place setting without washing her hands or performing hand hygiene.</p> <p>-at 12:25 p.m., CNA #1 lathered her</p>				

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	<p>hands for less than 10 seconds and served a resident a meal tray.</p> <p>-at 12:32 p.m., CNA #1 used alcohol hand gel, moved a resident's wheelchair and a chair, then moved the resident's wheelchair again and placed clothing protectors on 2 different residents. Without hand washing or hand hygiene, CNA #1 began cutting up a resident's meal and feeding the resident and then feeding another resident.</p> <p>- at 12:36 p.m., CNA #17 carried a room tray from the far side of the dining area, through the common area and by the nurses station to a resident's room with the dome not completely covering the food on the plate.</p> <p>7. An observation during the evening meal in the South dining room on 1-22-2015 at 5:16 p.m., indicated the Administrator washed her hands by keeping her hands under the running water during the entire handwashing process and then served a resident their meal tray.</p> <p>A current facility policy "Handwashing", updated on 8/22/12 and provided by the CDM on 1/27/15 at 11:27 a.m., indicated "...It is the policy...to ensure that staff</p>			

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F000431 SS=E	<p>will wash hands frequently as needed throughout the day following proper hand washing procedure...Clean hands and exposed portions of arms...immediately before engaging in food preparation including working with exposed food...1. When to Wash Hands...After coughing, sneezing...After handling soiled equipment or utensils...2. How to Wash Hands...Scrub well with soap and additional water as needed, scrubbing all areas thoroughly...Scrub for a minimum of 10-15 seconds within the 20-second hand washing procedure...."</p> <p>This deficiency was cited on the annual Recertification survey on 2-14-2014 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>						

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	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure treatment powders/creams/ointments had a documented open date, resident name and physician name on the container, expired medications removed; over the counter medications labeled with the resident's name and physician name; narcotic medications were in secured and/or unexposed packaging; treatment supplies were dated as to when opened and medication drawers were free of loose pills for 4 of 5 medication carts and 5 of 5 treatment carts observed.</p>	F000431	F-431 It is the practice of Woodview, a Waters Community, to ensure that drugs and biologicals used in the facility are labeled in accordance with the currently accepted professional principles and include all appropriate accessory and cautionary instructions including the expiration date. Currently, treatment powders/creams/ointments and supplies have an "opened" date indicated. The resident's name and the name of the physician's name are on the containers of all meds and treatments. Expired meds have been removed.	02/27/2015

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	<p>Findings include:</p> <p>1. On 1/22/15 at 10:40 a.m. the Southwest Unit was observed with LPN #4. The treatment cart was observed with the following noted: Two tubes of Bacitracin ointment were opened and not dated when they were opened; two bottles of Nystatin powder were opened and not dated when opened; a bottle of Sterile water, which had 200 ml remaining from the 1000 ml bottle, had no name, no date opened and would expire 4/2016.</p> <p>On 1/22/15 at 10:50 a.m. the Medication Cart on the Southwest Unit was reviewed with LPN #4. LPN #4 indicated there was a bottle of Lubricant Eye drops, which lacked documentation of the resident's physician. The Narcotic drawer was observed with the following: The medication cards were observed to have the pills enclosed in a bubble type packaging on a card, with a foil backing, which, when ruptured, the pill would be removed. A card of oral Xanax 0.25 mg was observed from the front to have 17 pills in the card. From the front of the card, pill #17 was observed to have a ruptured foil back to the bubble but the pill remained in the bubble. When the card was turned over, the ruptured foil to pill #17 had been covered with paper</p>		<p>Narcotic meds are in a secure and/or unexposed packaging area. Med drawers are free of loose pills. Any resident who receives meds or treatments in the facility has the potential to be affected by this finding. The DON/Designee will audit all med/treatment carts weekly x 4 weeks then monthly thereafter. At this time all aspects of proper labeling and storage of meds/treatments as well as cleanliness of the med/treatment carts per the Medication Storage policy will be audited. Any discrepancies will be corrected as found. (Exhibit12) An in-service held for nursing staff who administer meds was held January 22, 2015. At this time all aspects of the Medication Administration and Medication Storage policies (including treatments) were reviewed. (Exhibit 13 &amp;13-1) Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. The Quality Assurance Committee will monitor monthly for at least six months, then reevaluate if a need to continue, the results results of the audits by the DON/Designee related to the med/treatment carts will be reviewed for patterns. However, all concerns will have been addressed/corrected as found.</p>				

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	<p>tape. At the time, the corresponding narcotic sign out log for the resident for Xanax 0.25 mg indicated the resident had 17 pills available on the card. LPN #4 indicated this pill was taped over because when they put the pill cards back in the medication cart, the foil covering on the back of the pill card rips. The piece of tape covering the bubble area for pill #17 was dated 12/19/14.</p> <p>On 1/22/15 at 10:55 a.m., another card in the narcotic drawer was observed. Tramadol 50 mg had 28 pills observed on the card and the corresponding log indicated there were 28 pills on the card. The foil back of pill #28 was observed to be ruptured and when the card was turned over to the backside, pill #28 was observed to be taped also. The tape on pill #28 was undated. LPN #4 indicated when there was a bubble pill that was ruptured and covered with tape, it would be disposed of it at the end of the shift and would not be given to a resident.</p> <p>On 1/22/15 at 11 a.m. LPN #4 was interviewed. She indicated she was unaware when the two medication ruptured bubbles occurred.</p> <p>On 1/22/15 at 3:15 p.m. LPN #3 was interviewed. She indicated she was the evening shift nurse. She opened the</p>			

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	<p>narcotic drawer on the Southwest unit medication cart. The card with the Xanax was observed, with pill #17 remained taped on the back of the card. The back of the bubble area for pill #17 was not completely covered with tape. The LPN #3 pulled out a roll of tape and applied tape of the back to cover the entire bubble of pill #17. Also, the Tramadol card was observed, and pill #28 remained taped on the back of the card. LPN #3 indicated if pills fall out of the medication cards, they are discarded. She also indicated the Tramadol pill, which was covered on the back of the card with tape, undated, should have been discarded since the tape was not dated.</p> <p>2. On 1/22/15 at 11 a.m. the Rehabilitation Unit was toured with RN #18. The treatment cart had the following observations made: In the top drawer were 3 opened bottles of Nystatin Powder with no open date documented on the container; 2 tubes of Bacitracin ointment with the resident name only, no physician name and no date the tubes were opened; RN #18 indicated the following creams were house stock, Hydrogel AG and Hydrogel Plain. Neither of these opened creams were dated when they were opened. Both tubes of cream were 1/2 empty; a tube of</p>			

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	<p>Silver Sulfadiazine Cream 1%, which had an open date of 11/8/13 and and expiration date of 2/2014.</p> <p>On 1/22/15 at 11:15 a.m. on the Rehabilitation Unit, the Medication cart was observed with RN #18. The following observations were made: a bottle of Selenium 200 mcg and Probiotic for a resident. RN #18 indicated the resident's mother provided these for the resident. Both of these over the counter medications only had the resident's name and lacked documentation of the physician's name; over the counter medications of D3-1000 mg, Brand Zyrtec Allergy Relief and Senna. Each of these bottles lacked the physician name.</p> <p>On 1/27/15 at 10:35 a.m. the DON was interviewed and also provided a copy of the "Medication Storage Survey Report." This report was dated 12/30/14 She indicated this report was what the pharmacy provided to her after their review of the medication and/or treatment carts. The report included, but was not limited to, the following: "Medication carts: Discontinued or expired meds removed from the carts...Treatment carts:...Discontinued or expired meds removed..."</p> <p>On 1/27/15 at 11:25 a.m. the Regional</p>			

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	<p>Vice President was interviewed. She indicated when the packaging of a narcotic tablet has been broken or ruptured, the narcotic should be disposed of.</p> <p>3. During an observation of the North Hall Treatment cart with LPN #16 on 1/22/15 at 10:47 a.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- One, opened 4 oz. (ounce) jar of AmeriPhor Moisturizing Ointment (skin moisturizer) was not labeled with a resident's name or an opened date on the jar.</li> <li>-One, opened 8 oz. bottle of Soapreme All-Purpose Lotion Soap (skin cleanser) was not labeled with a resident ' s name or an opened date on the jar.</li> <li>-Three, opened 4 oz. tubes of Remedy Skin Repair Cream (for dry, itchy, irritated skin) were not labeled with Residents ' names or opened dates on the tubes.</li> <li>-One, opened tube of Vasolex Ointment (debridement of wound tissue) was labeled with a resident ' s name, but was not labeled with an opened date on the tube.</li> </ul>				

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	<p>-Two, opened 4 oz. tubes of CalaSoothe Ointment (moisture barrier) were not labeled with a residents' names or opened dates on the tubes.</p> <p>-One, opened 5.6 oz. tube of Protective Ointment Skin Protector (moisture barrier) was not labeled with a resident ' s name or an opened date on the tube.</p> <p>-One, opened 4 oz. bottle of Sterile Saline 0.9% Solution (Normal Saline) was not labeled with a resident ' s name, with an opened date of 1/22/15 on the bottle.</p> <p>-One, opened 4 oz. tube of Hydrogel Wound Dressing (maintain moisture in wounds) was not labeled with a resident ' s name or an opened date on the tube.</p> <p>-One, 7 oz. tube of Soothe &amp; Cool Moisture Barrier Ointment with Aloe and Vitamin A, D and E was not labeled with a resident ' s name or an opened date.</p> <p>-One, opened tube of Vasolex Ointment 60 gm (gram) was not labeled with a resident ' s name or an opened date.</p> <p>-One, opened tube of Fluocinonide Cream 0.1% (a steroid for inflammation) 120 gm was not labeled with a resident ' s name or an opened date. The tube had</p>			

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	<p>only the edge of a pharmacy applied prescription label.</p> <p>-One opened Natural Nasal Inhaler (saline inhaler) was not labeled with a resident name or an opened date.</p> <p>An interview with LPN #16 on 1/22/15 during observation of the North Hall treatment cart indicated all of the ointments, creams, soaps and the inhaler should be labeled with the Resident ' s name and the opened date. She indicated the unlabeled treatment supplies would be discarded.</p> <p>On 1/22/15 at 10:56 a.m., LPN #16 was observed to gather all of the unlabeled treatment creams, ointments, soap and the nasal inhaler and put them in a clear plastic trash bag and gave them to the ADON for disposal.</p> <p>4. During an observation of the South Hall Medication cart with LPN #11 on 1/22/15 at 11:03 a.m., the following OTC (Over The Counter) medications were observed:</p> <p>- One bottle of Vitamin C (supplement) 500 mg (milligrams) was not labeled with a Resident ' s name or a Physician ' s name on the bottle.</p>			

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	<p>- One bottle of Naproxen Sodium (for pain) 220 mg was labeled with a Resident ' s name but the Physician ' s name was not on the bottle.</p> <p>-One bottle of Acetaminophen ES (Extra Strength) (for pain) 500 mg was not labeled with a Resident ' s name or a Physician ' s name on the bottle.</p> <p>-One bottle of Vitamin D3 (a supplement) 2000 IU (International Units) was not labeled with a Resident ' s name or a Physician ' s name on the bottle.</p> <p>-One bottle of Aspirin (for pain, blood circulation) 81 mg was not labeled with a Resident's name or a Physician's name on the bottle.</p> <p>An interview with LPN #11 on 1/13/15 during observation of the unlabeled OTC medications indicated she was not aware the OTC medications were not labeled. She indicated the OTC medication bottles should be labeled with the Resident ' s name and administration instructions and a Physician ' s name.</p> <p>5. During an observation of the South Hall Treatment cart with LPN #11 on 1/22/15 at 11:15 a.m., the following was</p>			

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	<p>observed:</p> <p>-One, opened 4 oz. tube of CalaSoothe was not labeled with a Resident ' s name or an opened date on the tube.</p> <p>-Three, opened 4 oz. tubes of Hydrogel AG Sliver Antimicrobial Wound Dressing (wound gel that moisturizes and kills microorganisms in wounds) were not labeled with Residents ' names or opened dates on the tubes.</p> <p>-One, opened 4 oz. tube of Hydraguard Skin Cream (moisture barrier) was not labeled with a Resident ' s name or an opened date on the tube.</p> <p>6. An observation of the medication and treatment carts in the Skilled unit with LPN #6 on 1-22-2015 from 10:45 a.m. - 11:10 a.m., indicated the following:</p> <p>Medication Cart</p> <p>-The second drawer had 1 large, oval, white pill, 1 round, blue pill, 1 oval, orange pill and 2 white 1/2 pills loose in the bottom of the drawer.</p> <p>-The third drawer had 1 round, yellow pill, 2 small, white pills and another white pill loose in the bottom of the drawer.</p>			

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	<p>-An interview with LPN #6 on 1-22-2015 at 11:00 a.m., indicated loose pills found in the bottom of the medication carts were given to the DON (Director of Nursing) and placed in used coffee grounds. Further interview with LPN #6 indicated there was a cleaning schedule for the medication and treatment carts that was completed by the 3rd shift nurse.</p> <p>-Containers of Mucinex, Occuvite, Ultimate Flora and Milk of Magnesia were not labeled with the physician name and only had the resident name on the containers.</p> <p>-a container of Aspirin 81 mg (milligrams) did not have a resident's or physician name on the container and only had a resident's initials on the container.</p> <p>-In the 3rd drawer on the right, a container of A\antacid tablets did not have a label with a resident and physician name. LPN #6 indicated she did not know which resident the antacid tabs belonged.</p> <p>-In the 3rd drawer on the right, 2 containers of Iron 65, a container of stool softener and a bottle of "Mucus Extended Relief" expectorant did not have a physician name on the label.</p>			

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	<p>-In the 3rd drawer on the right, a box of Omeprazol DR (delayed release) 20 mg capsules did not have a resident or a physician name on the box.</p> <p>Treatment Cart</p> <p>-In the top drawer, an unlabeled partially used tube of bacitracin ointment and 2 tubes of partially used Santyl were not labeled with a resident or physician name.</p> <p>-An interview with LPN #6 on 1-22-2015 at 11:05 a.m., indicated she could not identify which residents the tubes of bacitracin and Santyl belonged.</p> <p>-In the 2nd drawer, a partially used tube of Biofreeze did not have a label to indicate which resident the Biofreeze belonged to.</p> <p>-An interview with LPN #6 on 1-22-2015 at 11:06 a.m., indicated she knew of only one resident that received the Biofreeze and "assumed it was her," but LPN #6 indicated the Biofreeze should have been labeled with the resident's and physician name on the container.</p> <p>-In the fifth drawer, there was a plastic bag with a tube of Medihoney, a box of Duoderm and 2 Mepilex Border boxes</p>			

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	<p>with a resident's name only.</p> <p>-An interview with LPN #6 on 1-22-2015 at 11:10 a.m., indicated hospice brought in the topical and LPN #6 indicated the facility nurse should have ensured the physician name was on the label.</p> <p>7. During an observation of the medication pass on the Rehabilitation unit on 1-23-2015 at 9:27 a.m., an over the counter Senna Laxative and a bottle of Vitamin D3 1000 IU (international units) tablets for a resident did not have the physician name on the bottles.</p> <p>An interview with LPN #7 on 1-23-2015 at 9:38 a.m., indicated over the counter medications should have a label with the resident name, physician name and room number.</p> <p>An interview with the Regional Vice President on 1-26-2015 at 1:15 p.m., indicated over the counter medications provided by the residents' families must follow the state rules and the medication labels would include the resident and physician name.</p> <p>A review of the January 2015 medication cart "Nurse Cleaning Schedule" for the skilled unit for the 11-7 shift indicated initials were in the box dated 1-22-2015</p>			

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	<p>per the instructions, "Nurse Please Initial to Signify task completed." An "X" indicated the task completed on 1-22-2015 was "Clean Medication Cart(s)"</p> <p>A copy of the "Nurse Cleaning Schedule" for the skilled unit, dated January 2015, was provided by the Assistant Director of Nursing on 1-22-2015 at 11:30 a.m. and indicated the following: "...when cleaning medication storage cabinets, refrigerators, carts-all medications and treatments should be observed for proper labeling, expired medications and date opened on open containers...."</p> <p>A policy "Drug Labels" last updated on June 19, 2012 and provided by the Administrator on 1-26-2015 at 1:15 p.m. indicated the following, "...Each prescription medication label includes resident's name, specific directions for use...strength of medication...physician's name...date medication dispensed...quantity...expiration date...." "...Nonprescription medications that are administered to a resident by nursing personnel, other than those take from floor stock, are dispensed...with a label meeting all requirements of a prescription label...."</p>			

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F000441 SS=D	<p>3.1-25(j)(k)(l)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <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</p>			
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	<p>of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff washed their hands or performed hand hygiene prior to preparing or administering medications for 10 of 26 passes by 3 of 7 nurses observed which affected 3 of 11 residents. (Resident #96, #28 and #88)</p> <p>Findings include:</p> <p>During an observation of the medication pass on 1-22-2015 at 4:16 p.m., LPN #2 was observed to give Resident #96 her medication without performing hand hygiene or hand washing prior to preparing the medication or prior to administering the medication to the resident.</p> <p>During an observation of the medication pass on 1-22-2015 at 3:45 p.m., LPN #3 was observed to give Resident #28 her medication without performing hand hygiene or hand washing prior to the medication preparation or prior to administering the medication to the resident.</p> <p>During an observation of the medication pass on 1-23-2014 at 9:25 a.m., LPN #7 was observed to give Resident #88 his 8 medications without performing hand</p>	F000441	<p>F-441 It is the practice of Woodview, a Waters Community, to 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. Currently, all staff who pass meds practice acceptable hand hygiene during the medication administration process. Any resident who has meds prepared/administered by the nursing staff have the potential to be affected by this finding. The DON/Designee will monitor 5 med passes weekly x 4 weeks then monthly thereafter. These will occur on various shifts. The monitoring will be to observe for proper infection control practices. Any issues will be corrected upon discovery, there fore prior to a breech in acceptable technique. (Exhibit 14)</p> <p>At an in-service held on February 11, 2015, for all staff the principles of proper hand hygiene as related to medication administration were reviewed. (Exhibit 4-1,4-2 A-D) Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. The Quality Assurance Committee will monitor monthly for at least six months then reevaluate if a need</p>	02/27/2015	



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	<p>record review the facility failed to ensure the facility's call light system worked in 7 of 32 rooms (Rooms 33, 101, 105, 110, 111, 116, 208) observed for functioning call lights in 3 of the 5 facility's units. (North Hall, Skilled Unit and the Southwest Hall).</p> <p>Findings include:</p> <p>An observation of the North Hall's call light system on 1/20/15 from 3:35 p.m. to 3:55 p.m. indicated the following:</p> <p>-At 3:40 p.m., Room 33-1's call light was not activated when the call light button for bed 1 was pushed several times by the resident and her visitor. The call light outside the door did not light or sound.</p> <p>-At 3:41 p.m., Room 33-2's call light was not activated when the large pillow-type call light for bed 2 was pushed. The call light outside the door did not light or sound.</p> <p>-At 3:42 p.m., Room 33's bathroom's call light was not activated when the cord for the call light was pulled, no sound or light outside the door was activated.</p> <p>An interview on 1/20/15 at 3:43 p.m. with CNA #30 indicated the call light above the room's door should blink a</p>		<p>Woodview, a Waters Community, to ensure that the nurses' station is equipped to receive a resident's call for assistance through a communication system from the resident's room as well as toileting and bathing areas. Currently, the call light system is working properly for all resident rooms as well as all toileting and bathing areas. All residents who reside in the facility have the potential to be affected by this finding. The call lights through out the facility (resident rooms and bathing and toileting areas) will be checked for functionality at least monthly as part of the Preventive Maintenance Program. (Exhibit 15) As call lights are found to be faulty, they will immediately be reported to the maintenance department via a requisition slip. At the daily CQI meetings any call lights known to be malfunctioning will be reported to maintenance. Bells will be given to residents for use (if they are able to use a bell) while their call lights are being repaired. If necessary, a temporary room change will occur to provide a working call light. An All Staff in-service held 2/17/15 the call light system and how to report problems was reviewed. (Exhibit 16 A-C) The Administrator will monitor the preventive Maintenance logs weekly for 4 weeks then monthly there after. The Quality Assurance Committee will monitor for at</p>	

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	<p>white light when the call lights was pushed by the Resident's bed and the same call light should flash red when the call light cord was pulled in the bathroom. The CNA indicated the call light must be broken and would need to be reported.</p> <p>An interview on 1/20/15 at 4:20 p.m., with Maintenance Manager indicated he fixed the call light in Room 33. He indicated the button on the wall cover plate was stuck. He indicated he does not check the call light system routinely and does not keep a record of the call light when last checked. He indicated he repairs the call lights when he was aware of one not working. He indicated staff are to write a work order if a call light is not working and needs fixed.</p> <p>On 1/20/15 at 3:35 p.m. the skilled unit call lights were observed. In room 105-2 , when the call light in the bathroom was activated from the resident's bathroom, the bathroom call light sound was heard however, the corresponding light over the resident's room, which was visible from the hall, did not illuminate.</p> <p>On 1/20/15 at 3:40 p.m. the call light in room 101-1 was observed. When the call light at the bedside was activated from the bedside, the call light did not sound</p>		least 6 months then reevaluate the need to continue.	

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	<p>and there was no corresponding light illuminated over the resident's door in the hallway.</p> <p>An observation of Room 111-1 call light on 1-20-2015 at 3:38 p.m., indicated when the bed call light button was pushed, no sound or light outside the door was activated in the skilled unit.</p> <p>An observation of Room 110-1 call light on 1-20-2015 at 3:47 p.m., indicated when the bed call light button was pushed, no sound or light outside the door was activated in the skilled unit. Further observation in room 110 indicated the call light in the bathroom did not have a pull string to activate the light, only a sharp metal piece that had to be pushed downward in order to activate the light.</p> <p>An observation of Room 116-1 call light on 1-20-2014 at 3:51 p.m., indicated when the bed call light button was pushed, the light did not light up outside the door.</p> <p>An observation of Room 208-2 call light on 1-20-2015 at 4:30 p.m., indicated when the bed call light button was pushed, the light did not sound or light up.</p> <p>An interview with CNA #15 on</p>			

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	<p>1-20-2015 at 3:57 p.m., indicated in the skilled unit, the bed call light should sound slow at the nurse's station and should flash white on the soffit at the end of the hall where the resident's room was located. Further interview with CNA #15 indicated the bathroom call light should sound fast at the nurse's station and should flash red on the soffit.</p> <p>An interview with Maintenance on 1-21-2015 at 12:00 p.m., indicated if there was a concern with a call light not working, he will push the call light cord end into the wall fixture to ensure it was secure and then test the call light. Further interview with Maintenance indicated, he may have fixed call lights by ensuring the call light cord end was secured in the wall, then pushing the call button without knowing the call light had not been working.</p> <p>An interview on 1/27/15 at 11:30 a.m., with Regional Vice President indicated the facility does not have a policy for monitoring the function of the Facility's call light system. She indicated Maintenance checked the call light monthly. She indicated a work order was to be placed with the maintenance department when a call light was not working and maintenance would check and repair the call light to make sure the</p>			

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	<p>light was working. She indicated there were bells available to give Residents if the call light could not be repaired right away.</p> <p>In an interview on 1/27/15 at 2:21 p.m., the Administrator indicated Maintenance Department checked the call light system monthly as evidenced by the initials monthly on the Environmental Maintenance log.</p> <p>A review of the Environmental Maintenance, dated 2014, provided by the Administrator on 1/27/15 at 2:21 p.m., indicated Maintenance initialed each month of 2014 for the following: "...Checking Rooms/Call lights...." The document did not indicated the number of rooms/call lights checked or which unit or which rooms/call lights were checked.</p> <p>This Federal tag relates to complaint IN00163168</p> <p>3.1-19(u)(1)</p>						