STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00140049. This visit was in conjunction with the investigation of Complaint IN00141048. Complaint IN00140049-Substantiated ; Federal deficiencies related to the allegations are cited at F 322. Survey dates: December 12, 13, 16, 17, 18, and 19, 2013. Facility number : 001149 Provider number : 155618 AIM number : 200145500 Survey team: Michelle Hosteter, RN-Team Coordinator Janet Stanton, RN Gloria Bond, RN Sandra Nolder, RN (12/12, 12/13, 12/17, 12/18, and 12/19/13) Census bed type: SNF: 45 SNF/NF : 30 Residential : 66 Total : 141	F000000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Census payor type: Medicare :16 Medicaid : 30 Other : 95 Total: 141 Residential Sample : 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on January 2, 2013.			

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on interview and record review the facility failed to ensure that a resident chose the number of showers per week they desired. This affected 1 out of 3 residents reviewed for Choices. (Resident #24). Findings include: On 12/12/2013 at 2:25 P.M., Resident #24 indicated she was informed she could take a shower twice a week. She used to take a shower daily and does not remember anyone asking her if she wanted to take one more than twice a week. Resident #24's record was reviewed on 12/17/2013 at 10:00 A.M. Diagnoses included, but were not limited to, weakness, difficulty in walking and diabetes. The resident's BIMS (Brief Interview for Mental Status) was 15 indicating she was cognitively intact.	F000242	F 242 SS=D Self-Determination-Right to make Choices It is the practice of this center to comply with F 242: Self-Determination-Right to make Choices What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 24 has been re-approached about her shower days & frequency. Corrections have been made to her Plan of Care that reflects her preferences. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this deficient practice. All residents' plan of cares' in regards to showers & frequency have been reviewed and updated to reflect the resident's preference. New residents upon admission will be approached about their preference for showers & frequency and their plans of care will be updated to reflect their preferences. What measures will	01/18/2014

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	During an interview on 12/17/2013 at 10:15 A.M., RN #1, who is also a Unit Manager, indicated residents are asked on admission what their preferences of shower days and frequency are. As to how a resident knows how to pick a different day, time and frequency later, she indicated they "should know" because the CNAs (Certified Nursing Assistants) asked them. In an interview regarding shower schedules and frequency with CNA #8 on 12/18/2013 at 11:59 A.M., she indicated she did not ask the residents if they wanted a change because she thought RN #1 went around and asked the residents if they wanted or needed a change. On 12/18/2013 at 1:28 P.M., RN #1 indicated she went around and asked all the residents in September regarding shower schedules and any changes they needed or wanted. She indicated she was not aware that Resident #24 wanted a change and she would see if she needs or wants a change in frequency it is offered and provided for her. 3.1-3(u)(1)		be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All Staff will be re-educated on Resident Rights including the Right to make choices. All new employees will be in-serviced upon hire during their orientation regarding Resident Rights. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Patient Care Coordinator or designee will audit a minimum of 10 residents weekly x 4 weeks to validate Shower & frequency Preferences. Any finding will be addressed as found. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician orders and a care plan regarding laboratory tests and supplements for 1 of 1 residents reviewed for following physician orders and care plans. (Resident #129) Findings include: Resident #129's record was reviewed on 12/17/13 at 2:43 P.M. Diagnoses included, but were not limited to, intracerebral hemorrhage, hypertension, aphasia, dysphagia, and cerebrovascular disease. The resident's current physician orders for nutrition included, but were not limited to: 11/18/13-House Supplements three times a day between meals. No consumptions could be found for the House supplement the physician had ordered on 11/18/13.	F000282	F 282 SS=D Services by Qualified Persons/Per Care Plan It is the practice of this center to comply with F-282: Services by Qualified Persons/Per Care Plan What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 129's physician orders and medical record were reviewed. Resident #129 is currently receiving her ordered nutritional supplements. Further Resident #129's labs tests are being done per the doctor's order. Results are received, recorded, reported and acted upon timely. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this deficient practice. Residents with physician ordered labs have been reviewed & verified for scheduling and completion/proper follow through. Residents receiving nutritional supplements have had their care plans reviewed & updated if needed. What measures will be put into place or what systemic	01/18/2014

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	A care plan dated 11/11/13, addressed the problem of "Nutritional status as evidenced by potential weight loss/gain related to edema, weight loss, diagnosis hypertension, acid reflux, hyperlipidemia, macular degeneration, history breast chance, history skin mean, fall risk, intracerebral/intervention hemorrhage." The interventions included, but were not limited to: 1. The staff were to encourage and assist the resident as needed to consume foods and/or supplements and fluids offered. 2. The resident should receive chance food as ordered. 3. The staff were to honor food preferences. 4. The staff were to obtain laboratory tests as ordered and notify the physician of the results. 5. The staff were to provide the diet as ordered. 6. The staff were to review the resident's weights and notify the physician and the responsible party of significant weight changes. 7. The resident would receive thickened liquids as ordered.		changes will be made to ensure that the deficient practice does not recur? Licensed Nursing Staff will be re-educated regarding Physician Orders and Laboratory Tracking Guidelines. Licensed Nursing Staff will be re-educated on the documentation of the patient consumption of physician ordered house supplements. This education will continue to be part of new nurse orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Director of Nursing or designee will track all physician ordered labs 5 days per week x 4 weeks, then all labs bi-weekly x 2 months on all shifts to validate completions and orders are followed. Any finding will be addressed as found. Director of Care Delivery or designee will audit a minimum of 10 residents per week x 4 weeks, then 10 residents' bi-weekly x 2 months on 1st & 2nd shifts to validate supplements are delivered to residents as ordered and consumption is documented for residents receiving House Supplements. Any finding will be addressed as found. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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	During an interview on 12/19/13 at 9:53 A.M., RN #1 who was the unit manager, indicated the house supplement was a 120 ml (milliliter) shake that came in a carton and was sent from dietary. She indicated the house supplement was ordered on 11/18/13. During an interview on 12/19/13 at 10:45 A.M., RN #1 who was the Unit Manager, indicated she had not gotten her house supplement that was ordered by the physician on 11/18/13. A document titled, "Incident Report-Patient Involved" dated 12/18/13, was provided on 12/18/13 at 3:16 P.M. The document indicated RN #12 had not placed the laboratory orders in the computer correctly and had not notified the laboratory so the laboratory tests were not drawn correctly. The physician's orders indicated there were laboratory tests ordered for 11/18/15 for an Albumin and Prealbumin and then a Prealbumin weekly on Mondays for four weeks. The resident had the Prealbumin Laboratory test drawn on these dates:			

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	The laboratory results for 11/18/13 indicated the Prealbumin was low, and on 12/03/13 the Prealbumin was low. There was no laboratory results found for the Albumin for 11/18/13, the Prealbumin for 11/25/13 or 12/09/13. A policy titled, "Laboratory Tracking Guidelines" dated 11/2013 was provided on 12/18/13 at 4:13 P.M., and deemed current. The policy indicated "PURPOSE:...the licensed nurse will validate when labs are drawn by signing the eTAR. labs not documented on will display as missed documentation to be completed prior to the end of the shift;...the center is responsible for contacting the lab for any results not received when expected, labs not drawn as ordered are reported to the attending physician for further direction and reported through the incident management system...." During an interview on 12/18/13 at 1:55 P.M., RN #1 who was the Unit Manager, indicated she could not locate the Albumin results for 11/18/13 and the Prealbumin results for 11/25/13 and 12/9/13. She indicated she had called the Laboratory and asked where the			

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	laboratory results were at. RN #1 indicated on 12/18/13 at 2:04 P.M., the Laboratory had not gotten any results for the Albumin for 11/18/13 or the Prealbumin other than the ones drawn on 11/18/13 and 12/03/13. She also indicated RN #12 took the laboratory orders off on 11/18/13, took them off wrong. She indicated she left a message with the physician and asked if he wanted the laboratory tests drawn now. Finally, she indicated the nurse who took off this resident's laboratory orders on 11/18/13 had placed the resident's laboratory tests in the laboratory book incorrectly and that was why RN #1 had not realized the results had not been sent back from the laboratory as ordered. 3.1-35(g)(2)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, interview and record review the facility failed to ensure hand sanitation procedures were followed during 2 pressure ulcer dressing changes. This impacted 1 of 1 residents observed for pressure ulcer dressing changes. (Resident # 156). Findings include: During a pressure ulcer wound care observation for Resident #156, on 12/17/2013 at 10:45 A.M., RN #11 was observed cleansing the pressure ulcer wounds after donning gloves, disposing of the cleansing pads in a bag, changing gloves to prepare the clean wound dressings, applying both clean wound dressings to both pressure ulcer wounds without washing or sanitizing her hands between glove changes.	F000314	F 314 SS=D Treatment/SVCS to Prevent/Heal Pressure Sores It is the practice of this center to comply with F 314-Treatment/SVCS to Prevent/Heal Pressure Sores What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 156's clinical record was reviewed and no negative outcomes were noted. Resident # 156's has her dressing(s) changed as ordered. All appropriate hand washing/hygiene and glove changes take place according to center policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with pressure sores and/or dressing changes have the potential to be effected by this deficient practice. A chart Audit was completed on all residents who currently receive	01/18/2014

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	In an interview on 12/17/2013 at 11:05 A.M., following the dressing changes, RN #11 indicated she washed her hands thoroughly before the dressing change and was sanitizing her hands after the dressing change but realized she did not sanitize her hands in between glove changes. The record of the facility's, "Dressing Change: Nonsterile (clean) and Sterile (aseptic)", dated 12/2009, was reviewed on 12/17/2013 at 3:30 P.M. Under procedure, the record indicated the following: "...8. Apply latex free non-sterile gloves. 9. Remove soiled dressing and discard in trash bag. 10. Assess wound according to current practice guide. 11. Remove latex free non-sterile gloves and discard in trash bag. 12. Perform hand hygiene...." 3.1-40(a)(2)		treatments for Pressure sores as part of the plan of care. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed Nursing Staff will be re-educated on guidelines for Dressing Change: Non-sterile (Clean) and Sterile (Aseptic) to include proper procedures as related to hand hygiene and glove changes during dressing changes. This education will continue to be part of new nurse orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Director of Nursing or designee will observe a dressing change & treatment to validate proficiency in hand hygiene/glove changing technique of 3 nursing staff a week x 4 weeks, then 3 nursing staff bi-weekly x 2 months to ensure proper hand sanitation procedures are followed. Any finding will be addressed as found. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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F000322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.			
	Based on observation, record review, and interview, the facility failed to discard tube feeding after hanging for 48 hours as manufacturers guidelines recommended for 1 of 3 residents reviewed for tube feeding. (Resident C) Findings include: The record review for Resident C was completed on 12/17/13 at 11 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbance, alcohol abuse, atrial fibrillation, high blood pressure. The Care Plan for tube feeding dated 1/20/09, included, but was not limited	F000322	F 322 SS=D NG Treatment/Services-Restore Eating Skills It is the practice of this center to comply with F 322 Treatment/Services-Restore Eating Skills What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # C's clinical record was reviewed. No Negative outcome was noted. Resident C currently receives feeding formula only for the accepted time frame (initial hanging to discard)as recommended by the manufacturer and per center policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All	01/18/2014

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	to, "... administer tube feeding formula, hydration, and flushes per order, change g-tube PRN for occlusion, check tube placement and residuals per protocol, observe and report any signs of aspiration or intolerance to feeding, provide care of tube insertion site per orders...." A recent significant change of condition was completed by the Dietician on 10/31/13. The assessment indicated the resident was on a regular mechanical soft diet. The note also indicated the resident was getting Jevity 1.2 at 60 milliters an hour on continuous pump. The tube feed was to run from 6 p.m., to 6 a.m. The resident also had problems that affected his ability to eat as evidenced by choking/coughing during meals or when swallowing medications. A progress note, dated 12/14/13 indicated, "...Tube feeding infusing through gastrostomy tube (GT) without problem, no residual noted...." On 12/17/13 at 2:30 P.M., a bottle of Jevity 1.2 tube feeding was observed hanging. The resident was not present in the room during the time of the observation. The bottle was dated 12/13/13. The bottle had		residents receiving tube feeding have the potential to be affected by this deficient practice. A chart Audit was completed on all other residents receiving tube feeding as part of the plan of care. All tube feedings were checked to validate manufactures guidelines are followed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed Nursing Staff will be re-educated on Enteral Tubes: Continuous (Pump) Feedings Policy. This education will continue to be part of new nurse orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Director of Care Delivery or designee will audit each resident receiving tube feeding 5 times a week x 4 weeks to validate manufactures guidelines are followed. Any findings will be addressed as found. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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	approximately 200 millilters left in it. In an interview on 12/17/13 at 2:41 P.M. , RN #1 who was a Unit Manager, indicated they use 600 milliliters at a time. She indicated the last time the feeding would have ran would have been of this morning. She indicated the policy for the tube feeding required the feeding was only to be hung for 48 hours. On 12/17/13 at 3:00 P.M., RN #1 provided a tube feeding policy. The policy titled, " Enteral Tubes: Continuous (pump) Feedings" dated 12/2009, indicated, "...follow manufacturer regarding hang times in the appendix of this manual...." The manufacturers information for Jevity 1.2 indicated, "...Hang product for up to 48 hours...." This federal tag relates to complaint # IN00140049. 3.1-44(a)(2)			

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F000323 SS=D	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 medication was not left at the bedside for 1 of 1 resident being reviewed for medications left at the bedside. (Resident #98) Findings Include: Resident #98's record was reviewed on 12/19/13 at 10:15 A.M. Diagnoses included, but were not limited to, left toe cellulitis. On 12/13/13 at 1:34 P.M., during a resident interview, a brown and orange capsule was observed in a plastic medication cup, (the resident's name written on the cup) was sitting on her over bedside table. During an interview on 12/13/13 at 1:46 P.M., RN # 7 indicated the capsule was Keflex (an antibiotic) 500 mg milligrams) and she had given it to the resident at 12:00 P.M. She indicated the resident had the medication cup with the capsule in	F000323	F 323 SS=D Free of Accident Hazards/Supervision/Devices It is the practice of this center to comply with F 323 Free of Accident Hazards/Supervision/Devices Wh at corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 98's medical record was reviewed and no negative outcome was noted. Resisdent#98 is receiving all of her medications as ordered and she is observed to be sure all oral medications are consumed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents receiving medications have the potential to be affected by this deficient practice. RN # 7 was re-educated on Medication Administration: Medications pass (12/13/2013). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed Nursing Staff will be re-educated on Medication Administration: Medication Pass Policy. This	01/18/2014

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	her hand and she had thought the resident took the pill. The resident had a physician order dated 12/12/13 for Keflex Capsule 500 mg by mouth three times a day until 12/20/13 for left toe cellulitis. On 12/13/13 at 1:44 P.M., the resident's call light was turned on for assistance. RN #1 who was the Unit Manager came into the resident's room to answer the call light. She indicated the brown and orange capsule was a pill, but she did not know what medication it was, or how long it had been sitting on the table. She indicated she would give the medication to the resident's nurse. A document titled, "Incident Report-Patient Involved," dated 12/13/2013, was provided on 12/13/13 at 3:54 P.M., by RN #1 who was a Unit Manager. The document indicated the nurse administered the Keflex capsule to the resident in the medication cup. The resident had placed the medication cup to her mouth and the nurse left the room. The resident had not taken the capsule, but the nurse thought the resident did. The nurse indicated she left the room before she had witnessed the resident swallowing the		education will continue to be part of new nurse orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Director of Care Delivery or designee will observe medication passes of 3 staff a week x 4 weeks to ensure medication administration guidelines are validated. Any findings will be addressed as found. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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	medication. A policy titled, "Medication Administration: Medication Pass," dated 03/2010, was provided on 12/18/13 at 4:13 P.M., by the Director of Nursing (DoN). The policy stated, "Purpose: To safely and accurately prepare and administer medication according to physician order and patient needs...8. Prepare medications for administration...remain with patient until administration of medication complete...." 3.1-45(a)(1)			

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to ensure nutrition interventions were put into place and all interventions had been evaluated to prevent a resident from experiencing weight loss. This impacted 1 of 3 residents reviewed for nutrition and weight loss. (Resident #129) Findings include: Resident #129's record was reviewed on 12/17/13 at 2:43 P.M. Diagnoses included, but were not limited to, esophageal reflux, dysphagia, and anorexia. The resident's weights for the last 90 days were as follows: 09/04/13-176 10/04/13-182	F000325	F 325 SS=D Maintain Nutrition Status Unless Unavoidable It is the practice of this center to comply with F 325 Maintain Nutrition Status Unless Unavoidable (See Response to F-282) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 129's medical record & plan of care has been reviewed and Nutritional interventions updated as needed in order to prevent weight loss unless medically unavoidable. Further, a meeting has been scheduled for the resident, family, nursing leadership, social service director and dietician to discuss a feeding tube as a possibility. The results of the meeting will be in the residents chart. The resident and family's wishes will be adhered too. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All	01/18/2014

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	11/06/13-160 11/13/13-156 11/20/13-155 11/26/13-154 12/04/13-150 12/10/13-150 The resident was admitted to the hospital on 10/25/13 and her weight recorded in the Emergency Room was 176 pounds. She had bilateral pedal edema upon admission to the hospital. She was readmitted to the facility on 10/31/13 and her readmission weight was 160 pound. The resident's current physician orders for nutrition included, but were not limited to: 11/01/13-Speech Therapy daily for five days per week for 30 days for treatment of speech, language, and hearing and dysphagia treatment. 11/08/13-Enhanced diet-Enhanced food at breakfast-discontinued on 11/19/13 11/12/13-Mirtazapine (Remeron) (Antidepressant) 30 mg (milligrams) by mouth at bedtime for anorexia and		residents having nutritional interventions have the potential to be affected by the deficient practice and have been identified through chart reviews. Identified residents requiring nutritional interventions have been updated as needed in order to prevent weight loss unless medically unavoidable. The possibility for a feeding tube will be discussed as an option if it has not been previously decided upon. The resident family, nursing leadership, social services and the dietician will attend these documented care plan meeting. The resident's wish will be honored. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The IDT (Inter disciplinary Team) will be in serviced on Weight Management Practice Guide: Nutritional interventions including feeding tubes. Licensed Nursing Staff and Registered Dietitian will be re-educated on Weight Management Practice Guide: Nutritional interventions. This education will continue to be part of new nurse orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? IDT Team (Inter Disciplinary Team) will discuss/review all weight loss for nutritional interventions once a	

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	restlessness. 11/14/13-Remeron (Mirtazapine) decreased to 15 mg by mouth every bedtime for 5 days then 7.5 mg by mouth every bedtime at 2200 (10:00 P.M.) for anorexia. 11/18/13-House Supplements three times a day between meals. 11/18/13-Prealbumin (laboratory test) every week on Mondays for four weeks. 11/18/13-Albumin (laboratory test) one time only. 11/19/13-Regular diet pureed texture-Regular thin liquids. 11/20/13-ProMod liquid give 30 ml (milliliters) by mouth three times a day for supplement. 11/20/13-Dietary to give lactose free supplement two times a day for poor appetite. 12/06/13-Ensure two times a day. No consumption's could be found for the House supplement the physician had ordered on 11/18/13. During an interview on 12/19/13 at 9:53 A.M., RN #1 who was the unit manager, indicated the house supplement was a 120 ml shake that came in a carton and was sent from dietary. She indicated the house supplement was ordered on 11/18/13.		week x 4 weeks, then once a week bi-weekly x 2 months to ensure nutritional interventions are current & updated. Any findings will be addressed as found. Registered Dietitian or designee will audit 5 resident Care Plans requiring Nutritional Interventions a week x 4 weeks to ensure nutritional interventions are validated. Any findings will be addressed as found. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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	During an interview on 12/19/13 at 10:45 A.M., RN #1 who was the Unit Manager, indicated she had not gotten her house supplement that was ordered by the physician on 11/18/13. A document titled, "Incident Report-Patient Involved" dated 12/18/13, was provided on 12/18/13 at 3:16 P.M. The document indicated RN #12 had not placed the laboratory orders in the computer correctly and had not notified the laboratory so the laboratory tests were not drawn correctly. The physician's orders indicated there were laboratory tests ordered for 11/18/13 for an Albumin and Prealbumin and then a Prealbumin weekly on Mondays for four weeks. The resident had the Prealbumin Laboratory test drawn on these dates: The laboratory results for 11/18/13 indicated the Prealbumin was low, and on 12/03/13 the Prealbumin was low. There was no laboratory results found for the Albumin for 11/18/13, the Prealbumin for 11/25/13 or 12/09/13. A policy titled, "Laboratory Tracking Guidelines" dated 11/2013 was			

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	provided on 12/18/13 at 4:13 P.M., and deemed current. The policy indicated "PURPOSE:...the licensed nurse will validate when labs are drawn by signing the eTAR. labs not documented on will display as missed documentation to be completed prior to the end of the shift;...the center is responsible for contacting the lab for any results not received when expected, labs not drawn as ordered are reported to the attending physician for further direction and reported through the incident management system...." During an interview on 12/18/13 at 1:55 P.M., RN #1 who was the Unit Manager, indicated she could not locate the Albumin results for 11/18/13 and the Prealbumin results for 11/25/13 and 12/9/13. She indicated she had called the Laboratory and asked where the laboratory results were at. RN #1 indicated on 12/18/13 at 2:04 P.M., the Laboratory had not gotten any results for the Albumin for 11/18/13 or the Prealbumin other than the ones drawn on 11/18/13 and 12/03/13. She also indicated RN #12 took the laboratory orders off on 11/18/13, took them off wrong. She indicated she left a message with the physician			

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	and asked if he wanted the laboratory tests drawn now. Finally, she indicated the nurse who took off this resident's laboratory orders on 11/18/13 had not placed the resident's laboratory tests in the laboratory book incorrectly and that was why RN #1 had not realized the results had not been sent back from the laboratory as ordered. The resident's meal consumptions were as follows: She had eight meals that were refused and an alternate meal was also refused and one meal that was refused and no alternate meal was document that it was offered to the resident. She had 16 meals that she ate 0-25% of her meals and there was no documentation that an alteration meal was offered to the resident. She had 29 meals that she ate 25% of her meals and the documentation for the alternate meal indicated no response was required. She had four meals that she ate that the documentation for the amount she consumed indicated not applicable.			

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	During an interview on 12/18/13 at 2:16 P.M., RN #1 indicated she had checked the calendar for the dates the meals were marked with a not applicable. She indicated the resident had not gone out of the facility on those dates. She had no idea why the CNA's would have marked not applicable instead of checking another choice for her food consumption. RN #1 also indicated if the resident had eaten 25% or less of a meal, the staff should be offering an alternate meal for the resident. She indicated that when the documentation read not applicable or no action required indicated the resident was not offered an alternate meal. During an interview on 12/18/13 at 4:45 P.M., the Director of Nursing indicated the facility did not have a policy for meal consumption or offering an alternate meal, but she expected the staff to offer an alternate meal for any residents who refused a meal or ate 25% or less of their meals. A care plan dated 11/11/13, addressed the problem of "Nutritional status as evidenced by potential weight loss/gain related to edema,			

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	weight loss, diagnosis hypertension, acid reflux, hyperlipidemia, macular degeneration, history breast chance, history skin mean, fall risk, intracerebral/intervention hemorrhage." The interventions included, but were not limited to: 1. The staff were to encourage and assist the resident as needed to consume foods and/or supplements and fluids offered. 2. The resident should receive chance food as ordered. 3. The staff were to honor food preferences. 4. The staff were to obtain laboratory tests as ordered and notify the physician of the results. 5. The staff were to provide the diet as ordered. 6. The staff were to review the resident's weights and notify the physician and the responsible party of significant weight changes. 7. The resident would receive thickened liquids as ordered. The resident's "Living Will Declaration" dated 8/19/10 she stated, "I wish to receive artificially supplied nutrition and hydration, even			

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	if the effort to sustain life is futile or excessively burdensome to me" There was no documentation found that had discussed a permanent feeding tube for artificial supplied nutrition as an option to prevent weight loss with the resident's daughter. During an interview on 12/18/13 at 1:30 P.M., the Speech Therapist #13 indicated the resident did not eat well and she pocketed food and did not allow staff to feed her. During an interview on 12/18/13 at 2:30 P.M., RN #1 who was the Unit Manager indicated she did not talk to the resident's daughter about a permanent feeding tube placement to artificially supply nutrition to the resident. During an interview on 12/18/13 at 4:45 P.M., the Director of Nursing indicated a permanent feeding tube placement to artificially supply nutrition to the resident had not been addressed with the resident's daughter. She indicated she would address it with her daughter in the morning when she comes into the facility to visit the resident.			

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	During an interview on 12/19/13 at 10:40 A.M., the Registered Dietician indicated she did not talk to the resident's daughter about a permanent feeding tube placement to artificially supply nutrition to the resident. During an interview on 12/19/13 at 10:50 A.M., the Social Service Director indicated she did not talk to the resident's daughter about a permanent feeding tube placement to artificially supply nutrition to the resident. 3.1-46(a)(1)			

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NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032	

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F000329 SS=D	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. 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.			
	Based on interview and record review, the facility failed to monitor specific behaviors to justify the use of antipsychotic and antidepressant medications for 3 of 5 residents and monitor blood pressures for 2 of 2 residents reviewed unnecessary medications. (Residents #76, #129 and #139) Findings include: 1. Resident #76's record was	F000329	F 329 SS=D Drug Regimen is Free from Unnecessary Drug It is the practice of this center to comply with F 329 Drug Regimen is Free from Unnecessary Drug What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 76, 129 & 139's medical records have been reviewed and updated as needed in order to address their mental, psychosocial, and behavioral symptoms & needs. Resident # 76's record identifies the	01/18/2014

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	reviewed on 12/17/13 at 9:20 A.M. Diagnoses included, but were not limited to, difficulty in walking, paralysis agitans (Parkinsons), and dementia unspecified without behavioral disturbances. The resident's current physician orders included, but were not limited to: 10/14/13- The Electronic Medication Administration Record (MAR) indicated, "... Monitor for side effects related to use of psychotropic medications. My initials indicate absence of signs and symptoms of side effects." The nurse was to initial the (EMAR) every shift. 10/14/13-Quetiapine Fumarate (Seroquel) (An Antipsychotic) 50 mg (milligrams) by mouth at bedtime for dementia with behaviors. 10/31/13-Seroquel (Quetiapine Fumarate) 25 mg by mouth daily related to dementia, unspecified, without behavioral disturbance. A care plan dated 8/4/2011 addressed a problem of "indicators of depression as evidenced related to diagnosis of depression".		indicators for any antipsychotic medications being used. A method for monitoring specific behaviors for the use of antipsychotic medications is in place. Resident # 129 record identifies the indicators for any antipsychotic medications being used. A method for monitoring specific behaviors for the use of antipsychotic medications is in place. Additionally any side effects and/or adverse effects of antidepressant medications are listed in the record as well. Further, Resident# 129 is receiving BP medication only when indicated as far as the ordered BR parameters. Blood pressures readings are taken as ordered are documented whenever they are taken. Resident # 139 record identifies behavioral indicators for the use of an antidepressant and an antianxiety medication. A method for monitoring specific behaviors for the use of antidepressants and antipsychotic medications is in place. Further, any side effects and/or adverse effects of antidepressant or antianxiety medications are listed in the record as well. Resident # 139 is receiving BP medication only when indicated as far as the order BP parameters. Blood pressures readings are taken as ordered are documented whenever they are taken. How other residents having the potential to be affected by the same deficient practice will	

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	The interventions included, but were not limited to: 1. The nursing staff were to administer his medication as prescribed by the physician, monitor the effectiveness of the medication and monitor for side effects of the medication. 2. The staff were to observe and report any changes in his mood. A care plan dated 3/27/2013 addressed a problem of the resident was "at risk for adverse effects related to the use of an antipsychotic medication". The interventions included, but were not limited to: The nursing staff were to to obtain ordered lab results and notify the physician of abnormal values. The resident's record lacked: a. Identified behavioral indicators for the use of an antipsychotic medication b. A method for monitoring specific behavioral indicators for the use of an antipsychotic medication. 2. Resident #129's record was reviewed on 12/17/13 at 2:43 P.M.		be identified and what corrective action(s) will be taken? All residents receiving psychotropic medications have the potential to be affected by the deficient practice and have been identified through chart reviews. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Social Service Director & Director of nursing will be re-educated on the Mood and behavior Practice guide inclusive of proper procedure identifying, tracking, and analyzing behaviors symptoms in order to address their mental and psychosocial needs. Licensed nursing staff will be Re-educated on the Mood and Behavior Practice guide inclusive of reporting behavior symptoms on the 24HR report that present a safety risk, interfere with care delivery, or are socially inappropriate or stressful to others. Licensed Nursing Staff will be re-educated regarding monitoring blood pressures & documentation in the clinical record. This education will continue to be part of new nurse orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Social Service Director or designee will complete a Behaviors Process Tool for all mood and behavior systems	

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	Diagnoses included, but were not limited to, dysphagia, anorexia, insomnia, intracerebral hemorrhage, hypertension, aphasia, and cerebrovascular disease. The resident's current physicians orders included, but were not limited to: 11/14/13-Remeron (an Antidepressant)15 mg by mouth at bedtime for anorexia. 11/26/13-Trazodone (an Antidepressant) 25 mg by mouth every 24 hours as needed for insomnia 12/4/13-Psychological/mental health evaluation and treatment by (named company) and Psychiatric evaluation and treatment by (named company) The resident's record lacked: a. Identified behavioral indicators for the use of an antidepressant medication b. A method for monitoring specific behavioral indicators for the use of an antidepressant medication. c. Identified side effects and/or		noted on the 24HR report that present a safety risk, interfere with care delivery, or are socially inappropriate or stressful to others 5 days a week x 8 weeks, then 5 times a week bi-weekly x 2 months in line with Mood and Behavior Practice Guide and facility policy. Any findings will be addressed as found. Director of Care Delivery or designee will audit 5 residents receiving Blood Pressure Medications based on physician ordered BP parameters 5 times a week x 4 weeks, then 5 times a week bi-weekly x 2 months to validate BP Medication is only given as ordered based on set parameters. Any findings will be addressed as found. The results of the audit will be submitted to the IDT Team & QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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	adverse effects of an antidepressant medications. The resident's physician orders for hypertension during October 2013 included, but were not limited to: 8/16/13-Amlodipidine Besylate (blood pressure medication) 2.5 mg (milligrams) tab take 1 tablet by mouth daily with 5 mg=7.5 mg Hold for SBP (systolic blood pressure) < (less than) 110. Amlodipine Besylate 5 mg tab take 1 tablet by mouth once daily with 2.5 mg=7.5 mg Hold for SBP <110. 8/12/13-Lisinopril (blood pressure medication) 20 mg by mouth daily Hold for SBP <110. 8/27/13-Metoprolol Tartrate(blood pressure medication) 25 mg take 1/2 tablet =12.5 mg by mouth twice daily. Hold if SBP <100. The following Blood Pressures (BP's) were not documented, or were documented below the parameters and the blood pressure medications were documented as given on the Medication Administration Record (MAR) when they should have been documented as being held on the MAR.			

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	10/08/13-8 P.M.-No BP found documented for Metroprolol Tartrate. 10/11/13-12 P.M.-No BP found documented for Metroprolol Tartrate. 10/18/13-8 A.M.-BP 108/56 Lisinopril was documented with an initial in the box as given on the MAR. 10/19/13-12 P.M.-No BP found documented for Metroprolol Tartrate. 10/19/13-8 P.M.-No BP found documented for Metroprolol Tartrate. 10/20/13-8 A.M.-No BP found documented for Amloipine Besylate. 10/20/13-8 P.M.-No BP found documented for Metroprolol Tartrate. The resident's physician orders for hypertension during November 2013 included, but were not limited to: 10/31/13-Amlodipine Besylate 2.5 mg daily by mouth for hypertension. Hold for SBP <110. 10/31/13-Metoprolol Tartrate 25 mg tablet give 12.5 mg by mouth two times daily for hypertension. Hold if SBP <110.			

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	The following Blood Pressures (BP's) were not documented, or were documented below the parameters and the blood pressure medications were documented administered when they should have been documented as held. 11/03/13-8 P.M.-BP 105/85 Metoprolol Tartrate was documented as administered on the MAR. 11/09/13-8 A.M.-BP 93/67 Amlodipine Besylate was documented as administered on the MAR. 11/09/13-8 A.M.-BP 93/67 Metoprolol Tartrate was documented as administered on the MAR. 11/12/13-8 P.M.-BP 100/68 Metoprolol Tartrate was documented as administered on the MAR. 11/13/13-8 A.M.-BP 102/70 Metoprolol Tartrate was documented as administered on the MAR. 11/26/13-8 P.M.-No documentation that the Metoprolol Tartrate was administered was located on the MAR and no BP was documented on the MAR.			

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	During an interview on 12/19/13 at 10:00 A.M., RN #1, who was the Unit Manager, indicated the BP for the resident on 10/20 could not be found in any of the documentation. She indicated the blanks on the MAR indicated an omission of a medication. She indicated if the initials were not circled on the paper MAR, then the medication was administered as prescribed. She indicated on the paper MARS, if the nurse held the medication the nurse would have circled her initials and documented on the back of the MAR why the medication was held. She indicated the check mark on the Electronic Medication Administration Record (EMAR) indicated the medication was administered as prescribed. She also indicated the number five on the EMAR indicated the medication had been held. 3. Resident #139's record was reviewed on 12/18/13 at 8:45 A.M. Diagnoses included, but were not limited to, difficulty in walking, anorexia, muscle weakness, agitation, depression, dementia unspecified without behavioral disturbance and hypertension.			

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	The resident's current physician orders included, but were not limited to: 10/14/13-Lorazepam (an Antianxiety) 0.5 mg tablet give 0.25 mg by mouth three times a day for agitation. 11/08/13-Mirtazapine (an Antidepressant) 7.5 mg by mouth at bedtime for depression. 12/03/13-Psychological and mental health evaluation and treatment by (name of company) and Psychiatric evaluation and treatment by (name of company). A care plan dated 10/9/13, addressed a problem that the resident was verbally and physically agitated and aggressive such as hitting, and yelling related to sensory overload and cognitive impairment. The resident's record lacked: a. Identified behavioral indicators for the use of an antidepressant and an antianxiety medication. b. A method for monitoring specific behavioral indicators for the use of an antidepressant and an antianxiety medication.			

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	c. Identified side effects and/or adverse effects of an antidepressant or an antianxiety medications. During an interview on 12/18/13 at 2:30 P.M., RN #1, who was the Unit Manager, indicated at the present time she only had one behavior she was monitoring, and that behavior was not for this resident. She indicated when a resident had a behavior, the behavior was placed on the 24 hour report sheet. Then the behavior was documented on for 72 hours in the progress notes by the nurses. She indicated the resident was monitored for adverse reactions for antipsychotics. During an interview on 12/18/13 at 4:16 P.M., the Social Service Director (SSD) indicated any behaviors displayed by a resident were documented on the progress notes or the 24 hour report sheet. Then the behaviors were evaluated the following day in the "Eagle Room" by the Interdisciplinary Team (IDT). The IDT evaluated the behaviors to assess if they were new behaviors and what interventions could be initiated, or to assess if the present interventions are effective. The			

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	nursing staff documented on the behavior in the progress notes for 72 hours. She indicated this resident did not currently have behaviors. The resident's physician orders for hypertension during October 2013 included, but were not limited to: 9/17/13-Metoprolol Succ ER (blood pressure medication) 100 mg by mouth daily. Hold for SBP < 100. Discontinued on 10/10/13 10/10/13-Metoprolol Succ ER 100 mg daily 10/10/13-Weekly Blood Pressures on Mondays. These were to be done on the 6-2 shift. The following Blood Pressures (BP's) were not documented, or were documented on another shift other than when the resident's BP was taken before or after the medication was administered. 10/01/13-No BP was not found documented on the MAR. 10/02/13-BP 113/69 was documented at 8:33 P.M., 12 hours after the medication was administered.			

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	10/03/13-BP 114/66 was documented at 2:28 A.M., five and a half hours before the medication was administered. 10/04/13-No BP was not found documented on the MAR. 10/05/13-No BP was not found documented on the MAR. 10/06/13-BP 149/80 was documented at 1:52 A.M., seven hours before the medication was administered. 10/07/13-BP 164/66 was document at 2:31 A.M., 5 and one half hours before the medication was administered. 10/07/13-BP 157/69 was documented at 10:45 A.M., two and one half hours after the medication was administered. 10/08/13-BP 153/73 was documented at 4:06 A.M., 4 hours before the medication was administered. 10/09/13-BP was not found documented on the MAR.			

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	During an interview on 12/19/13 at 10:00 A.M., RN #1, who was the Unit Manager, indicated if the initials were not circled on the paper MAR, then the medication was administered as prescribed. She indicated on the paper MARS, if the nurse held the medication the nurse would have circled her initials and documented on the back of the MAR why the medication was held. She indicated the check mark on the Electronic Medication Administration Record (EMAR) indicated the medication was administered as prescribed. She also indicated the number five on the EMAR indicated the medication had been held. During an interview on 12/19/13 at 10:30 A.M., RN #1, who was the Unit Manager indicated the BP's on 10/2, 10/3, 10/6, 10/7, and 10/8 were the only BP's she located documented in the resident's record. 3.1-48(3) 3.1-48(4)			

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F000371 SS=E	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			
	Based on observation, interview and record review, the facility failed to ensure foods were dated and labeled properly, a kitchen appliance was cleaned and the floor was not swept for 1 of 1 kitchens observed for sanitation and food storage. This deficit practice had the potential to affect 72 of 75 residents receiving food from the kitchen. Findings include: A kitchen tour was conducted on 12/12/13 at 9:58 A.M., with the Kitchen Manager in attendance. The following was observed: A. The walk in cooler was observed to have two thickened apple juices that were delivered on 12/10/13 and were opened, but they did not have an open or use by date on them. The walk in cooler was observed to	F000371	F-371 SS=E: Food Procure, Store/Prepare/Serve-sanitary It is the practice of this center to comply with F-371 – Food Procure, Store /Prepare/Serve-sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Thickened liquids identified on 12/12/13 that were not dated and labeled were immediately discarded on 12/12/13. Items in dry storage identified on 12/12/13 (bottle of vegetable oil, bottle of vanilla flavoring, bag of dry roasted peanuts and bag of egg noodles) that were not dated and labeled were all immediately discarded on 12/12/13. Items on the bread shelves identified on 12/12/13 (22 dinner roll packages, 4 submarine buns packages and 4 hamburger buns packages) that were not dated and labeled were immediately discarded on 12/12/13. Items in the reach-in cooler identified on 12/12/13 (2 long metal pans with smaller metal pans inside) that were not covered properly, dated and labeled were immediately	01/18/2014

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	have one lemon flavored thickened water which was delivered on 11/3/13 and was opened, but it did not have an open or use by date on it. During an interview at this time, the Kitchen Manager indicated the thickened beverages should have been labeled with an open date when they were opened. B. The dry storage area was observed to have a bottle of vegetable oil and a bottle of vanilla flavoring that was open without an open or use by date on them. During an interview at this time, the Kitchen Manager indicated the bottles should have been labeled with an opened date. The dry storage area was observed to have a bag of dry roasted peanuts that had been opened on 11/1/13 with a use by date of 12/1/13. During an interview at this time, the Kitchen Manager indicated the peanuts should have been disposed of, and he threw them away. The dry storage area was observed to have a bag of egg noodles left in the bag in the plastic container. There		discarded on 12/12/13. The grill that was identified on 12/12/13 to have debris on the handles, the ledge and front of the grill was thoroughly cleaned on 12/12/13 to remove the debris. The oven that was identified on 12/12/13 to have burnt black debris over the edge and on the front of it was thoroughly cleaned on 12/12/13. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the deficient practice. Thickened liquids that were opened were checked for proper dates and labeling on 12/12/13 with no additional corrections needed. Dry Storage was inspected on 12/12/13 to ensure that items were properly dated, labeled and stored with no additional corrections needed. Bread Shelves were inspected for opened packages and reviewed with proper dates and labels on 12/12/13 with no additional corrections needed. Coolers were inspected on 12/12/13 to ensure that items were properly dated, labeled and stored with no additional corrections needed. Equipment, including the grills and ovens, were cleaned on 12/12/13 to ensure that there was not debris on these items. What measures will be put into place or what systemic changes will be made to	

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	were other egg noodles that were laying in the container out of the bag and the bag of egg noodles were laying on top of the loose noodles. During an interview at this time, the Kitchen Manager indicated the egg noodles should have been poured into the plastic container, not left in the bag. C. The bread shelves were observed to have 22 dinner rolls packages, 4 submarine buns packages and 4 hamburger buns packages, that had been opened, but were not labeled with an open date. During an interview at this time, the Kitchen Manager indicated these packages should have been labeled with an open date when they were opened. D. The reach-in cooler was observed to have 2 long metal pans with smaller metal pans inside the long pans and the plastic wrap was partially covering the long metal pans. The individual smaller pans were not covered or labeled with a use by date. One of the long pan was observed to have six individual metal pans with two types of salads, two types of sliced meats and two types of sliced		ensure that the deficient practice does not recur; Dietary Staff will be re-educated on guidelines for proper dating, labeling and storage of opened thickened liquids, opened bread items, items in dry storage and items in the coolers. In additional, dietary staff will be re-educated on guidelines for proper cleaning of cooking equipment. Cleaning schedule was revised for cooking equipment, including the grills and ovens, to be deep cleaned 2x a week to ensure that debris is cleaned thoroughly in additional to the current schedule of cleaning equipment in between shifts. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; General Manager of the Dietary department will complete audits weekly x 4 weeks of proper dating, labeling and storage of opened thickened liquids, opened bread items, items in dry storage, items in the coolers and of the cleaning schedule. Any findings will be addressed as found. The results of the audits will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed; January 18, 2014	

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	cheese. During an interview at this time, the Kitchen Manager indicated the items of food in the individual metal pans were identified as tuna salad, chicken salad, slices of ham, slices of turkey, slices of American cheese and slices of Swiss American cheese. He indicated each item in the individual metal pan needed to be individually wrapped and labeled. The other long pan was observed to have four individual metal pans with lettuce, sliced pickles, sliced tomatoes and sliced onions. During an interview at this time, the Kitchen Manager indicated the items of food in the individual metal pans were identified as lettuce, pickles, tomatoes and onions He indicated the individual metal pans needed to be individually wrapped and labeled with the use by date and the name of the item of food. E. On the front line area, brown sticky debris was observed around the handles of the grill. Dried brown debris was observed on the ledge of the grill. Brown burnt debris was observed on the front of the grill.			

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	During an interview at this time, the Kitchen Manager indicated the brown debris was grease around the grill handles. He indicated the brown dried debris was eggs that had spilled over the ledge of the grill, and the burnt brown debris on the front of the grill was burnt eggs. He indicated the grill was deep cleaned on Mondays and was wiped down between each shift. F. There was burnt black debris observed over the edge and on the front of the oven. During an interview at this time, the Kitchen Manager indicated the burnt black debris was a buildup of grease on the oven. He indicated the ovens were deep cleaned every Monday and wiped down between each shift. A document titled, "Food Safety Product Labeling & Dating Guide-U.S." with a revised date of 8/2009 was provided on 12/12/13 at 3:30 P.M., by the Kitchen Manager. This document stated, "Food safety product labeling and dating requirements for Sodexo operations...Purchased, ready-to-eat food removed from original container. Sodexo standard: Food left over after meal service: Use within 2 days (for			

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	quality reasons). Advance production (food prepared for later use): Use within 5 days (for food safety reasons). If held at 40 F (4 C) or below and if clearly marked with "use by date" (day or date product must be consumed, sold or discarded).... 3.1-21(g)(3)			

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F000441 SS=E	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F000441	F 441 SS=E Infection Control It is the practice of this center to	01/18/2014

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	ensure 1 of 3 licensed nurses performed appropriate hand hygiene, disposable glove use, and glucometer sanitizing procedures in a manner to prevent cross-contamination for infection control purposes, in 1 of 3 observations of a finger-stick blood sugar (Accu-check) test using a glucometer. In addition, the facility failed to maintain resident equipment, mechanical lift (Hoyer lift) and wheelchair on 1 of 4 nursing units, in a clean and sanitary condition. (R.N. #5, and Residents #75, #148, #152, and #156) Findings include: 1. On 12/17/13 at 3:50 P.M., R.N. #5 was observed while preparing and performing an Accu-Check test on Resident #152. The nurse opened a top drawer in the medication cart and obtained the glucometer, and placed it on top of the cart on the bare surface. She gathered some packets of alcohol wipes and a lancet, and placed them in a small plastic medicine cup. The nurse opened the bottle containing the reagent test strips for the glucometer, and removed one of the strips by the test pad using her bare fingers. She placed the strip into the cup with the other supplies, picked up the cup and		comply with F 441 SS=E Infection Control What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #148 and #156's clinical record was reviewed and no negative outcomes were noted. Resident #148 receives their oral medications by nurses who use proper infections control practices as related to administration of medications. Resident #156 has a wheelchair that is clean including the seat. The seat is adequately padded. Resident # 75 no longer resides at the facility. Resident # 152 no longer resides at the facility. RN # 5 was re-educated on Hand Hygiene, Gloves: non-sterile/sterile procedure and Glucose Blood Monitoring Equipment procedure guidelines 12/17/2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the deficient practice and have been identified through chart review. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All Staff will be re-educated on guidelines for proper hand hygiene. Licensed nursing staff will be re-educated on Gloves: non-sterile/sterile	

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	glucometer and went into the resident's room. After speaking with the resident for a few minutes, RN #5 put on disposable gloves, inserted the reagent test strip into the glucometer, laid it on top of the resident's bed cover, wiped the resident's finger with an alcohol wipe, and used the lancet to obtain a blood bead. Following the test, the nurse disposed of all supplies in the sharps container in the room, removed the disposable gloves, and left the room. She placed the glucometer on top of the medication cart on the bare surface. She had not washed her hands or used a hand sanitizer before or after leaving the resident's room. On 12/17/13 at 3:58 P.M., RN #5 was observed while preparing to perform an Accu-Check test and administer some medications for Resident #75, who was the next resident following Resident #152. The nurse did not wash her hands or use a hand sanitizer. After using an alcohol wipe on the glucometer, she set it down on the top of the medication cart, on the bare surface.		procedure and Glucose Blood Monitoring Equipment procedure guidelines to prevent cross contamination. Certified Nursing Aides will be re-educated on proper cleaning procedures for resident equipment, mechanical lifts and wheelchairs to create a sanitary environment. This education will continue to be a part of initial orientation for nurses and certified nurse aides. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Each Department head or designee will observe hand washing with a minimum of 10 staff per week on all shifts for proper techniques per facility guideline x 4 weeks. Any findings will be addressed as found. Director of Care or designee will observe and randomly audit 10 staff on proper cleaning procedures for resident equipment, mechanical lifts and wheelchairs 3 times a week x 4 weeks, then 10 staff a week bi-weekly x 2 months for proper sanitation guidelines. Any findings will be addressed as found. Director of Nursing or designee will observe Accu-Check Tests of 5 staff for Glucometer Sanitation x 4 weeks, then 5 staff a week bi-weekly x 2 months to validate center guidelines. Any findings will be addressed as found. The results of the audits will be submitted to	

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	She dispensed the medications for Resident #75 into a medicine cup; then removed a reagent strip from the multi-strip bottle with her bare fingers, and placed it in another small plastic medicine cup with packets of alcohol wipes and a lancet. She picked up the glucometer and the cups with the medication and finger-stick supplies, and carried them down to Resident #75's room. The resident was not in the room or on the unit. RN #5 indicated the resident's spouse frequently took her off the unit. The nurse carried the medication and Accu-check supplies back to the medication cart. She labeled the cup with the pills, and placed in a drawer in the cart. She placed the glucometer back on top of medication cart, on the bare surface. Without washing her hands or using a hand sanitizer, RN #5 prepared and administered pill medication for Resident #148. In an interview on 12/17/13 at 4:06 P.M., RN #5 indicated there was a special "cleaner" for the glucometer, which was usually kept in the medication cart. She took out one of the sanitizer wipe packets from a top drawer of the medication cart, held it out, and indicated this was the		the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed? January 18th , 2014	

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	sanitizer wipe. However, she stated "I'm an 'old' nurse--I just use alcohol wipes [to sanitize glucometer] between each resident." In an interview on 12/17/13 at 4:20 P.M., RN #6, the Unit Manager, indicated all nurses had been educated about the correct way to sanitize a glucometer using the bleach wipes. She indicated each nurse was to sanitize the glucometer at the start of their shift, and then between each resident use. On 12/19/13 at 1:00 P.M., the Director of Nursing provided 3 Policy/Procedures related to hand hygiene, glove use, and glucometer sanitization. The Policy/Procedures included, but were not limited to, the following information: "HAND HYGIENE (12/2009) When to wash hands or use an alcohol-based hand rub: Before applying and after removing gloves; ...After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient...." "GLOVES: NON-STERILE/STERILE (12/2009) PROCEDURE: NON-STERILE--1. Perform hand hygiene; ...3. Apply			

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	latex fee non-sterile gloves one at a time; ...6. Perform hand hygiene...." "GLUCOSE BLOOD MONITORING (FINGER STICK BLOOD SUGAR) (01/2011) EQUIPMENT: ...EPA approved hypochlorite solution (1:10 bleach wipes) or an approved germicidal disinfectant. PROCEDURE: ...5. Perform hand hygiene; 6. Apply latex free non-sterile gloves; ...17. Clean blood glucose meter utilizing an EPA approved bleach wipe or approved germicidal disinfectant.; 18. Remove gloves and perform hand hygiene...." 2. During an initial tour observation on 12/12/2013 at 10:00 A.M., the hoyer lift in E hall on the first floor, was observed with significant sandy color residue in the foot area and smudges throughout the lift that included a dark finger print mark and smear like prints. Another hoyer lift in the hallway was observed at with dark residue on the base of it. The belt portion of the lift was observed with an oval gray mark on it and dirt. In an observation and interview with RN #6 on 12/19/2013 at 9:45 A.M., she indicated she agreed the stand			

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	up lift was soiled and another lift observed was also dirty. On 12/17/2013 at 10:40 A.M., Resident #156's wheelchair was observed with a chair pad with gray like residue on it. On 12/19/2013 at 8:55 A.M., a newly admitted resident unnamed was observed pushing her wheelchair. The wheelchair lacked padding on the wheelchair seat and there was visible residue/soilage on the seat. 3.1-18(l)			
R000000	The following residential deficiencies were cited in accordance with 410 IAC 16.2-5.	R000000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

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R000272	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview and record review, the facility failed to ensure foods were dated and labeled properly, a kitchen appliance was cleaned and the floor was not swept for 1 of 1 kitchens observed for sanitation and food storage. This deficit practice had the potential to affect 66 residents out of 66 residents in the facility. Findings include: A kitchen tour was conducted on 12/12/13 at 9:58 A.M., with the Kitchen Manager in attendance. The following was observed: A. The walk in cooler was observed to have two thickened apple juices that were delivered on 12/10/13 and were opened, but they did not have an open or use by date on them. The walk in cooler was observed to have one lemon flavored thickened water was delivered on 11/3/13 and was opened, but it did not have an open or	R000272	R 272 – Food and Nutritional Services It is the practice of this center to comply with R 272 – Food and Nutritional Services What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Thickened liquids identified on 12/12/13 that were not dated and labeled were immediately discarded on 12/12/13. Items in dry storage identified on 12/12/13 (bottle of vegetable oil, bottle of vanilla flavoring, bag of dry roasted peanuts and bag of egg noodles) that were not dated and labeled were all immediately discarded on 12/12/13. Items on the bread shelves identified on 12/12/13 (22 dinner roll packages, 4 submarine buns packages and 4 hamburger buns packages) that were not dated and labeled were immediately discarded on 12/12/13. Items in the reach-in cooler identified on 12/12/13 (2 long metal pans with smaller metal pans inside) that were not covered properly, dated and labeled were immediately discarded on 12/12/13. The grill that was identified on 12/12/13 to have debris on the handles, the ledge and front of the grill was thoroughly cleaned on 12/12/13 to remove the debris. The oven that	01/18/2014

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	use by date on it. During an interview at this time, the Kitchen Manager indicated the thickened beverages should have been labeled with an open date when they were opened. B. The dry storage area was observed to have a bottle of vegetable oil and a bottle of vanilla flavoring that was open without an open or use date on them. During an interview at this time, the Kitchen Manager indicated the bottles should have been labeled with an opened date. The dry storage area was observed to have a bag of dry roasted peanuts that had been opened on 11/1 with a use by date of 12/1. During an interview at this time, the Kitchen Manager indicated the peanuts should have been disposed of, and he threw them away. The dry storage area was observed to have a bag of egg noodles left in the bag in the plastic container. There were other egg noodles that were laying in the container out of the bag and the bag of egg noodles were		was identified on 12/12/13 to have burnt black debris over the edge and on the front of it was thoroughly cleaned on 12/12/13. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the deficient practice. Thickened liquids that were opened were checked for proper dates and labeling on 12/12/13 with no additional corrections needed. Dry Storage was inspected on 12/12/13 to ensure that items were properly dated, labeled and stored with no additional corrections needed. Bread Shelves were inspected for opened packages and reviewed with proper dates and labels on 12/12/13 with no additional corrections needed. Coolers were inspected on 12/12/13 to ensure that items were properly dated, labeled and stored with no additional corrections needed. Equipment, including the grills and ovens, were cleaned on 12/12/13 to ensure that there was not debris on these items. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary Staff will be re-educated on guidelines for proper dating, labeling and storage of opened thickened liquids, opened bread items,	

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	laying on top of the loose noodles. During an interview at this time, the Kitchen Manager indicated the egg noodles should have been poured into the plastic container, not left in the bag. C. The bread shelves were observed to have 22 dinner rolls packages, 4 submarine buns packages and 4 hamburger buns packages, that had been opened, but were not labeled with an open date. During an interview at this time, the Kitchen Manager indicated these packages should have been labeled with an open date when they were opened. D. The reach-in cooler was observed to have 2 long metal pans with smaller metal pans inside the long pans and the plastic wrap was partially covering the long metal pans. The individual smaller pans were not covered or labeled with a use by date. One of the long pan was observed to have six individual metal pans with two types of salads, two types of sliced meats and two types of sliced cheese. During an interview at this time, the		items in dry storage and items in the coolers. In additional, Dietary Staff will be re-educated on guidelines for proper cleaning of cooking equipment. Cleaning schedule was revised for cooking equipment, including the grills and ovens, to be deep cleaned 2x a week to ensure that debris is cleaned thoroughly in additional to the current schedule of cleaning equipment in between shifts. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; General Manager of the Dietary department will complete audits weekly x 4 weeks of proper dating, labeling and storage of opened thickened liquids, opened bread items, items in dry storage, items in the coolers and of the cleaning schedule. Any findings will be addressed as found. The results of the audits will be submitted to the QA&A Committee for further review and recommendations. By what date the systemic changes will be completed; January 18, 2014	

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	Kitchen Manager indicated the items of food in the individual metal pans were identified as tuna salad, chicken salad, slices of ham, slices of turkey, slices of American cheese and slices of Swiss American cheese. He indicated each item in the individual metal pan needed to be individually wrapped and labeled. The other long pan was observed to have four individual metal pans with lettuce, sliced pickles, sliced tomatoes and sliced onions. During an interview at this time, the Kitchen Manager indicated the items of food in the individual metal pans were identified as lettuce, pickles, tomatoes and onions He indicated each time in the individual metal pan needed to be individually wrapped and labeled with the use by date and the name of the item of food. E. On the front line area, brown sticky debris was observed around the handles of the grill. Dried brown debris was observed on the ledge of the grill. Brown burnt debris was observed on the front of the grill. During an interview at this time, the Kitchen Manager indicated the brown debris was grease around the grill			

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	handles. He indicated the brown dried debris was eggs that had spilled over the ledge of the grill, and the burnt brown debris on the front of the grill was burnt eggs. He indicated the grill was deep cleaned on Mondays and was wiped down between each shift. F. There was burnt black debris observed over the edge and on the front of the oven. During an interview at this time, the Kitchen Manager indicated the burnt black debris was a buildup of grease on the oven. He indicated the ovens were deep cleaned every Monday and wiped down between each shift. A document titled, "Food Safety Product Labeling & Dating Guide-U.S." with a revised date of 8/2009 was provided on 12/12/13 at 3:30 P.M., by the Kitchen Manager. This document stated, "Food safety product labeling and dating requirements for Sodexo operations...Purchased, ready-to-eat food removed from original container. Sodexo standard: Food left over after meal service: Use within 2 days (for quality reasons). Advance production (food prepared for later use): Use within 5 days (for food safety			

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	reasons). If held at 40 F (4 C) or below and if clearly marked with "use by date" (day or date product must be consumed, sold or discarded)....			

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R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			
	Based on record review and interview, the facility failed to ensure employees received their second tuberculin skin test within allowed 1-3 weeks time frame for 2 of 16 employees reviewed for tuberculin skin tests. (CNA # 9 and # 10) Findings include: There were 5 randomly selected new hire employee files reviewed on 12/19/13 at 2:00 P.M. The employee record for CNA #9 was	R000410	R 410 – Infection Control It is the practice of this center to comply with R 410 – Infection Control What corrective action(s) will be accomplished for those residents found to have been affected by the non-compliance? Employee # 9 had her TB test restarted on 10/23/2013 and completed with the second step on 11/1/2013.Employee # 10 had her TB test restarted on 10/15/2013 and completed with the second step on 10/25/2013. How other residents having the potential to be affected by the same non-compliant practice will be	01/15/2014

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	reviewed. CNA #9 was hired 8/27/13. The first step tuberculin skin test was completed on 8/28/13 but there was no second step tuberculin test documented in the chart. The employee record for CNA #10 was reviewed. CNA #10 was hired 9/3/13. The first step tuberculin skin test was completed on 8/30/13 but there was no second step tuberculin test documented in the chart. In an interview on 12/19/13 at 2:15 P.M., the Human Resource Coordinator indicated she was on medical leave in August and someone else was covering for her. She indicated she did not have a second step for either of those employees done within 1 to 3 weeks of the first step.		identified and what corrective action(s) will be taken? All current employee records and new hires were reviewed for timely tuberculin skin testing.All current and newly hired employees have current TB skin testing results and are present in their employee files. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Initial 2-step TB tests of newly hired employees will be logged on and maintained in a separate file and kept by the Human Resources Director.Each month, the Executive Director/designee will inspect for completion of timely TB testing of newly hired employees. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put in place? The Executive Director/designee will provide ongoing monitoring for 3 months of all newly hired employees for timely TB skin testing, utilizing the TB file and report the results to the QAA committee for further review and recommendations. By what date the systemic changes will be completed? January 15, 2014	