STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVE ELKHART, IN 46517

(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
F0000	This visit was for Recertification and State Licensure. This visit included the Investigation of Complaint IN00117264. IN00117264 Unsubstantiated due to lack of evidence. Survey dates: October 15, 16, 17, 18, 19, 22, 23, and 24, 2012 Facility number: 000039 Provider number: 155685 AIM number: 100275130 Survey team: Shelly Vice, RN, TC Carol Miller, RN Debra Kammeyer, RN Census bed type: SNF/NF: 159 Total: 159 Census payor type: Medicare: 20 Medicaid: 110 Other: 29 Total: 159 Residential sample: 8	F0000		

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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 11/1/12 Cathy Emswiller RN			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation and record review, the facility failed to ensure 1 of 3 residents reviewed, of 3 who met criteria, received oral care, a clean shirt after eating and remained unexposed (shirt raised up) from hallway. (Resident #9) **Findings include:** On 10-16-12 at 9:38 a.m. an observation of Resident #9 indicated there was food on the resident's shirt. It appeared to be scrambled eggs. The resident was drooling. His mouth and drool had food in it. A nurse and CNA entered the room to reposition the resident. The nurse removed the egg from the resident's shirt by wiping the shirt off and food contents fell to floor. No oral care observed from 9:38 a.m. to 11:30 a.m. On 10-16-12 at 2:41 p.m., the resident was observed from the hallway as door was open. The resident was in bed with his eyes closed, with a clean shirt on but it had been pulled up and exposed the abdomen. On 10-23-12 at 3:00 p.m., the resident was observed from the hallway lying in bed, eyes open, shirt up and abdomen exposed The CNA #50 entered room at 3:05 p.m. and	F0241	**F 241 1. Resident #9 had no adverse outcomes related to the alleged deficient practice. The facility has purchased new clothing for resident #9 to ensure residents' abdomen was not exposed. Please refer to F-312 for the oral care, both residents received oral care as defined by the plan of care. Resident 179 and resident #92. Residents' residing at the facility have to potential to be affected by the alleged deficient practice. *Guardian Angels will monitor residents with ill fitting clothes as well as food particles on resident clothing, on a daily basis and refer to Social Services as needed. 3. Licensed Nurses and Certified Nursing Assistants have been in-serviced on Protection of Residents Dignity which will include residents with ill fitting clothing and food particles on residents clothing and making referrals to Social Services for residents' with ill fitting clothing by 11/23/12 * Department Managers have been in-serviced by the**	11/23/2012

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	covered resident with a blanket. On 10-23-12 at 3:14 p.m., Social Service note dated 9-7-12 titled The Behavior Management Review for August, indicated the resident had no behavioral issues throughout the month in review. The review stated, "resident's quality of life and dignity continue to be maintained...resident is cleaned, appropriately dressed and well groomed each day". 3.1-3(t)		**Executive Director on protection of residents' dignity and Social Services referrals for residents with ill fitting clothes by 11/23/12. Department Managers will observe for residents with ill fitting clothes during the guardian angel round process and will make referrals to Social Services when appropriate. 4. Social Services referral audits as well as dignity rounds will be completed by the Director of Social Services and the Director of Clinical Education. The results of the rounds and audits will be forwarded to the QA&A committee monthly for 6 months and then the QA&A team will determine the need for additional auditing Until a threshold of 100% is acheived. 5. Date of Compliance 11/23/12**	

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview, observation and record review, the facility failed to implement activities and revise approaches as appropriate for a cognitively impaired resident, for 1 of 11 sampled residents. (Resident #9) Findings include: The clinical record of Resident #9 was reviewed on 10-23-12 at 3:05 p.m. The resident's diagnoses included but not limited to: diabetes insulin dependant, bipolar disorder, schizoaffective disorder, Alzheimer's disease, epilepsy, senile dementia. Parkinson's disease, and peripheral vascular disease. On 10/16/2012 at 9:13 a.m., the resident was observed in his room watching television (TV) while sitting in his wheelchair. An interview with resident's wife on 10-17-12 at 10:12 a.m., indicated the resident "sometimes had to leave activities when he gets loud". He attended bingo when wife goes with resident. She was unsure if he does any activities when she isn't there. She believed resident attended church but isn't sure. On 10-18-12 at 8:50 a.m., the resident was	F0248	**F-248** **1. Resident #9 has had his care plan revised to include additional approaches/interventions to maintain his activity interests/needs. There were no adverse outcomes related to the alleged deficient practice.** **2. Residents' with cognitive impairments residing at the facility have the potential to be affected by the alleged deficient practice.** **3. Activity personnel have been in-serviced by 11/23/12 on implementing additional interventions/ approaches for residents with Cognitive impairments by the Director of Clinical Education.** *** Residents' admitted to the facility and who have Cognitive impairments will be assessed by the Activity Department. The Activity Department will interview families to ensure all activity interests are obtained/captured and care planned to the interests of the resident.** **4. Activity participation logs will be reviewed monthly for 6 months, any decrease in Activity participation will result in additional activity approaches/interventions. Results from the Activity logs will be forwarded to the QA&A committee monthly for 6 months and the**	11/23/2012

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	observed in his room watching TV while sitting in wheelchair. At 2:40 p.m. resident was observed in bed On 10-19-12 at 10:03 a.m., the resident was observed sitting in his wheel chair beside his bed, TV on and his eyes were closed. The resident's head was down and not supported. 10-19-12 at 2:33 p.m., observed the resident in bed. 10-22-12 10:15 a.m., an observation of resident in room in front of TV, eyes closed sitting in wheelchair. 10-23-12 at 9:00 a.m. an observation of the resident indicated he was sitting in his wheelchair in front of TV. The resident had his eyes open and stated he was watching TV. 10-23-12 at 11:10 a.m., observed the resident in bed getting brief changed, then the resident was returned to the wheel chair. 10-23-12 at 3:00 p.m., an observation indicated the resident was in bed with his eyes open, his shirt was up and abdomen was exposed. The CNA #50 was observed entering room at 3:05 pm and covered resident. On 10-23-12 at 3:10 p.m., the Recreation Services Note dated 9-26-12 was reviewed and indicated no changes are being made at this time to his activity care plan or his recreational assessment. He attended facility programs such as bingo and church. His wife tried to come on Fridays so she can play bingo with him in Rosewood dining room. At times resident had behaviors such as		**quarterly thereafter.** **Date of Compliance: 11/23/12**	

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	screaming out during programs that interrupt the speaker and other residents. If behavior continued staff removed resident from the activity and took him back to room/unit. The resident's free time was spent watching TV and listening to WFRN on the radio. The family had a moving picture frame in room that viewed family and friends photos that the resident sits and watched. He attends small group program on unit when able. On 10-23-12 at 3:14 p.m., the Social Service Note dated 9-7-12 titled The Behavior Management Review for August, indicated the resident had no behavioral issues throughout the month in review. The review stated, "resident's quality of life and dignity continue to be maintained...resident is cleaned, appropriately dressed and well groomed each day". On 10-23-12 at 3:20 p.m. the review of care plan indicated that Resident #9 had displayed inappropriate behavior during group activities exhibited by yelling out and interrupting others. The goal for the resident was for resident to demonstrate appropriate behaviors during group activities. Interventions included but not limited to: bring resident to activities just before activity begins as resident doesn't like to sit for long periods of time, gently remind resident not to interrupt others, and if the resident disrupts the program the staff was to redirect and remind the resident if behavior continues the resident may be asked to leave the activity. On 10-24-12 at 8:35 a.m., the interview with Activity Director indicated the resident attended church and bingo when wife was with him, which was most of the time. The resident liked to watch TV, listen to music and			

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	reminisce. He received engagement pre meal, and tactile stimulation. On 10-24-12 at 8:40 a.m., the review of Recreation Participation Record indicated the resident had gone to church on 10-7 and 10-14. He attended bingo three times this month and one period of reminiscing. He also attended two social events on the 8th and 15th of October. The record also indicated the resident had participated in the following: Television/radio, visitor's and reading daily. 3.1-33(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			
	Based on interview, observation, and interview the facility failed to ensure oral hygiene for 2 of 5 reviewed residents, of 17 residents who meet the criteria. (Resident #9 and Resident #179) Findings include: 1. On 10-17-12 at 11:43 a.m., an interview with the resident's sister indicated that Resident #179 is presently having gum irritation with bleeding and swelling. The resident was seeing a dentist tomorrow and was taking an antibiotic prior to seeing the dentist for the irritated gums. The sister stated, the resident's "breath has been terrible for a while, I really don't think anyone was brushing her teeth". The sister included in her interview, that at one point when hospice services first started she was concerned that the facility's staff was ignoring her sister's needs. She believed that has been resolved.	F0312	**F- 312 1. Resident # 179 had her dental needs identified prior to the survey entrance. On 10/15/12 Nursing identified residents gums swollen and red. A physicians order was obtained and resident was started on a prophylactic antibiotic in addition to a dental consult. This resident was admitted to the facility with broken, loose and carious teeth which the responsible party (Husband) declined aggressive treatment due to the residents overall health condition. Resident #9 had his teeth cleaned as indicated on the plan of care as well as resident #179. There were no adverse outcomes related to the alleged deficient practice. Future dental needs will be forwarded to Social Services for appropriate follow up. 2. Residents dependent upon staff for their oral care have the potential to be affected by the alleged deficient practice. Residents who are dependent for oral care were examined and oral care provided if indicated. 3. Nursing staff**	11/23/2012

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	On 10-17-12 at 1:35 p.m., the observation of resident #179 indicated the breath had a foul odor to it and teeth are not clean from previous meal. The clinical record of Resident #179 was reviewed on 10-17-12 at 12:03 p.m. The resident's diagnoses included but not limited to: Alzheimer's Disease, and unspecified psychosis. The nursing notes were reviewed and indicated the resident had reddened and swollen gums. An order was received for an antibiotic and to make an appointment with a dentist. On 10-17-12 at 12:05 p.m., a review of nursing notes dated 10-16-12 from hospice indicated no infection and no new orders . On 10-18-12 at 10:04 a.m. an interview with resident's sister indicated the dentist appointment was over and resident had "severe periodontitis". The dentist indicated to the sister that the resident had received "poor oral care" The sister stated, ' I'm upset the dentist wants her to see an oral surgeon to remove all her teeth, I don't think she can make it thru the surgery".		**were in-serviced by the Director of Clinical Education by 11/23/12 on providing dependent residents oral care with return demonstration as well as Social Service referral forms. * Guardian Angels will monitor residents' oral health during rounds 5x per week with Weekend managers observing for oral care needs. Any oral care needs will be directed to the charge nurse for immediate follow up. * Nursing notes will be reviewed by Nursing Administration to ensure dental needs are forwarded to Social Services for appropriate follow up. 4. Social Services referral forms will be audited by the DNS/Designee. The results of those audits will be reported by the Social Services Director monthly for 6 months and then the QA& A Team will determine the need for additional auditing until a threshold of 100% is acheived5. Date of compliance 11/23/12**	

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	On 10-18-12 at 10:00 a.m., the review of Dental Group progress note indicated the resident had "severe inflammation, heavy plaque and tarter. The resident needed someone to water brush her teeth every day 3 times daily to keep her mouth and body healthy". On 10-18-12 at 10:05 a.m., the review of MDS assessment dated 7-24-12 indicated the resident was an extensive assist for personal hygiene and totally dependent on staff for oral care. On 10-18-12 at 10:12 a.m., the review of The Care Plan, indicated the resident was on hospice related to end of life care dated 4-23-12 with interventions listed but not limited to: coordinate care with hospice. Another Care Plan reviewed indicated the resident was self care deficit (dated 5-4-12) related to end stage Alzheimer's with a goal to meet all needs of bathing, grooming and hygiene and comfort thru next review. Interventions included but not limited to: oral care assistance, dental exams as necessary, and meet all needs of bathing, grooming, hygiene, nutrition and comfort.			

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	On 10-18-12 at 1:50 p.m. an interview with hospice RN #56 indicated that she seen the resident twice a week on Tuesdays and Thursdays. The hospice aide was at the facility 3 times a week on Monday, Wednesday and Fridays. The resident was bathed twice a week, a sponge bath once a week, which includes "mouth cleaning". The aide had a facility nurse sign her paper prior to her leaving the facility so the nurses are aware of when the resident is no longer receiving care from the hospice aide. On 10-18-12 at 2:00 p.m., the hospice chart form titled The Initial Plan of Care for Hospice Care indicated the resident will have personal care needs met with assistance of CNA/Aide. A Nursing Assessment Update for resident dated 10-5-12 was reviewed and indicated oral cavity normal. The Hospice Aide Assignment Plan of Care dated 10-5-12 was reviewed and indicated personal care for resident includes oral care at every visit (3 times a week). On 10-19-12 at 7:10 a.m., an interview with CNA #57 indicated residents are given oral care daily (brushing of the teeth or dentures)			

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	and as needed. On 10-19-12 at 7:25 a.m., RN #58 interview indicated resident is a total assist (unable to care for herself) with activities of daily living which includes oral care. On 10-22-12 at 11:15 a.m., the hospice aide visit form indicated visits dated 4-23-12 thru 10-19-12 that aide on duty had seen the resident 3 times a week (Monday, Wednesday and Friday's) and checked marked each visit that oral care was done. On 10-23-12 at 11:13 a.m., an interview with CNA #60 indicated that she was washing the residents gums/teeth with water and toothbrush or toothette after each meal. CNA #60 was with resident at the dentist and was aware of physician's order. She also indicated that at times the resident clenches jaw and unable to get the toothbrush in mouth. On 10-23-12 at 11:13 a.m., the review of Treatment Administration Record indicated nurses sign that oral care (brushing with water) occurred three times a day as ordered by dentist. On 10-24-12 at 11:15 a.m. review of			

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	medical records did not indicate oral care wasn't completed due to resident clenching her jaw shut. 2. On 10-16-12 at 9:10 a.m., the observation of Resident #9, indicated resident was sitting in a wheelchair in his room, facing the television and his call light was on his bed. The resident was unable to reach the call light. There was food on the resident's shirt. It appeared to be scrambled eggs. The resident was was drooling. The resident was missing his upper and lower front teeth and a moderate amount of food was pocketed in the cheeks of the resident. The resident's fingernails are unclean and untrimmed. A nurse and CNA entered the room to reposition the resident. The nurse removed the egg from the resident's shirt by wiping the shirt off and the contents fell to floor. No oral care (teeth brushing or rinsing of the mouth) observed during the interaction with resident and staff at time of repositioning. No oral care observed that morning. On 10-16-12 at 9:20 a.m., the interview with LPN #61 indicated resident could use the call light and placed call light near resident.			

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	On 10-17-12 at 10:48 a.m., the interview with Resident's wife indicated that resident wore a brief to absorb urine when he urinates. She expressed concern if the brief was changed often enough as the resident complains to wife that his bottom is sore. The wife did not indicate a smell in the room and stated, "he has a thick pad on wheelchair for him to sit on but the hoyer sling is on top of the pad. She voiced no concerns regarding oral care but did mention that his missing teeth were not going to be replaced by dentures because she didn't believe he would keep dentures in his mouth. She stated her husband is on a pureed diet and that helps him to eat. The clinical record of Resident #9 was review on 10-18-12 at 1:45 p.m. indicated the resident would accept dental care. The resident's diagnoses included, but not limited to: diabetes insulin dependant, bipolar disorder, schizoaffective disorder, Alzheimer's disease, epilepsy, senile dementia, Parkinson's disease, and peripheral vascular disease. On 10-18-12 at 1:50 p.m., a review of the Care Plan indicated the resident had a physical functioning deficit			

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	related to requiring extensive assist with bed mobility, eating, and total dependence with toileting, Interventions included but not limited to: call bell within reach, nail care weekly and as needed, oral care twice a day and as needed. Dental exams as necessary. On 10-23-12 at 3:14 p.m., the Social Service note dated 9-7-12 titled The Behavior Management Review for August, indicated the resident had no behavioral issues throughout the month in review. The review stated, "resident's quality of life and dignity continue to be maintained...resident is cleaned, appropriately dressed and well groomed each day". On 10-24-12 at 9:24 a.m., an observation of the resident's mouth indicated he had white thick salvia and teeth appeared to have a film on them. The resident's breath had an odor. Resident #9 indicated that staff did not brush his teeth after breakfast. When asked if staff brush his teeth daily he stated, "at night" 3.1-38(a)(3)(C) 3.1-38(a)(3)(E)			

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F0431 SS=A	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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. 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. 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. 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. Based on observation and interview the facility failed to remove expired medications from the medication refrigerator in 1 of 4 medication rooms observed.	F0431	**F-431 1. The expired medications were removed from the Medication Room Refrigerator at the time of the notification. There were no**	11/23/2012

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	(Resident #113) Findings include: On 10-17-12 at 2:30 p.m., an observation was made of the Southwest Unit medication storage room with LPN #51 . The refrigerator contained medication that required refrigeration. The refrigerator temperature was 40 degrees Fahrenheit. The observation of the expiration dates of medication stored in the refrigerator indicated five Hydrocortisone Acetate 25 mg suppositories expired on 3/2012, twenty-five expired on 7/2012 and remaining doses expired in 2013 for Resident #113. The LPN indicated that expired medications should not be stored after their expiration date. The LPN stated she would removed the expired medication from the refrigerator and destroy medication per the policy and procedure. On 10-18-12 at 10:30 a.m., an Expiration Dating and Document Requirement and Policy & Procedure titled Disposal of Medication was received from the DNS and indicated outdated medications shall be destroyed according to policy. An interview with the DNS insured the medications were destroyed and provided documentation that indicated the destruction policy was implemented. 3.1-25(o)		**residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Licensed Nursing staff have been in-serviced by the Director of Clinical Education on the policy and procedure of Expiration, Dating and Disposal of medications by 11/23/12 * Unit Managers will inspect the Medication Refrigerator 5 times per week to ensure no expired medications exist. * Nursing Administration will inspect the Medication Room Refrigerators 3 times per week to ensure no expired medications exist. 4. The Director of Nursing will conduct Medication Room Audits monthly for 6 months. Results of those audits will be forwarded to the QA&A committee monthly for 6 months and then the QA&A team will determine the need for additional auditing until a threshold of 100% is achieved.Date of Compliance 11/23/12**	

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F0441 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, record review, and interview the facility failed ensure	F0441	**F-441** **1. LPN #53 & 54 were re-educated on**	11/23/2012

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	gloves were worn when needed and hands washed for a sufficient length of time, during care observations for 3 of 3 residents observed. (Resident #174, Resident #136,and Resident #10) Findings include: On 10-17-12 at 9:20 a.m. an observation was made of LPN #53 administering an insulin injection to Resident #179 without gloves on. On 10-17-12 at 9:21 a.m., an observation of LPN #53 indicated she had completed giving an insulin injection to Resident #179 and did not have gloves on. The LPN #53 had no gloves on when she was observed giving the resident a solution to swish in his mouth and then spit solution out into a cup. The resident had small amount of solution on his face. She indicated she would return to wipe his face. The LPN went into bathroom and washed her hands with soap and water for 7 seconds. The LPN left the room and returned. She washed the resident's face then washed her hands for 7 seconds and left room. On 10-17-12 at 9:28 a.m., an observation of LPN #54 indicated she washed her hands for 11 seconds after passing medication to Resident #136. On 10-18-12 at 9:10 a.m. the LPN #54 was observed at medication cart with two Insulin syringes filled with doses of medication (Lantus and Humalog) lying on paperwork,		**the policy related to wearing gloves during patient care which includes the administration of insulin. The 2 nurses were also re-educated on the hand washing policy. There were no adverse outcomes related to the alleged deficient practice.** **2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.** **3. Licensed nursing staff has been in-serviced by the Director of Clinical Education by 11/23/12 on the procedure for wearing gloves when appropriate as well as the hand washing policy and procedure. The Director or Clinical Education will complete random Licensed Nursing competencies on the hand washing process.** *** The Director of Clinical Education will perform clinical competencies 2x per week and on-going. The Director of Clinical Education will perform Medication pass observations 2x per week to ensure proper glove and hand washing is performed by licensed staff.** **4. Nursing Administration and/or the Director of Clinical Education will complete hand washing/ Insulin administration monthly for 6 months. Results from those audits will be forwarded to the QA&A committee monthly for 6 months and then quarterly thereafter. The QA&A committee will determine the need for additional auditing.** **5 Date of Compliance 11/23/12**	

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	one syringe needle tip was touching the paper work (no longer sterile). The LPN turned to transport the syringes into Resident #10's room and was stopped prior to giving injection due the one syringe had been contaminated by touching the paperwork. She was unaware that she had contaminated the syringe. She removed the medication and disposed of both syringes in a sharps container. The LPN indicated she is unsure what the policy states about how she could keep the syringes from becoming contaminated and how to transport the exposed needle of the syringe into a resident's room. On 10-18-12 at 11:00 a.m., a policy titled Medication Administration Subcutaneous Insulin dated 10/07 was received from the DNS and indicated to recap needle using safety device to permit safe sterile transportation. On 10-18-12 at 2:00 p.m., a review of the policy titled Handwashing/Hand Hygiene undated indicated employees must wash their hands for at least 15 seconds before and after direct resident contact On 10-19-12 at 10:30 a.m., an interview with the Infection Control RN #55, indicated the nurses were to wear gloves while giving insulin injections. The use of gloves was part of the infection control education. 3.1-18(l)			

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F0465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to ensure the facility was free of urine odor. This deficiency affected 1 of 4 units (Southwest Unit). Findings include: On 10/17/12 at 3:05 p.m. there was a smell of urine odor by room 407. On 10/19/12 at 9:00 a.m. on the Southwest unit on 3 of 3 hall there was a smell of urine odor. On 10/23/12 at 10:45 a.m. there was a smell of urine odor outside of room 409. On 10/24/12 at 9:00 a.m. an interview with the housekeeper #1 in regard to deep cleaning the rooms and she indicated she deep cleans 2 rooms a day. Housekeeper #1 further indicated deep cleaning the residents room includes moping the floor, wiping down the mattress, and cleaning the bathroom and toilet. On 10/24/12 at 9:30 a.m. a form titled Deep Clean Calendar for October 2012 indicated room 407 was deep cleaned on	F0465	**F-465 1. There were no residents directly affected by the alleged deficient practice. Rooms 407 and 409 were deep cleaned with no odor of urine present. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been in-serviced by the Director of Clinical Education on reporting urine odors to the Director of Housekeeping services by 11/23/12. * Housekeeping staff will continue to utilize the deep cleaning schedule on this unit to ensure no future odors persist. * Guardian Angels will report any urine odors to the Director of Housekeeping services 5 x per week, in addition weekend managers will complete rounds and report any urine odors to housekeeping staff if indicated. * The Executive Director and the Housekeeping Director will complete rounds monthly for 12 months. 4. The Director of Housekeeping services will conduct room audits monthly for 12 months. The results of these audits will be forwarded to the QA&A committee**	11/23/2012

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	10/20/12 and room 409 was deep cleaned on 10/21/12. 3.1-19(f)		**monthly for 12 months. The QA&A committee will examine those results and determine the need for additional auditing. Date of Compliance 11/23/12**	