STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH ALTERNACARE	1104 E GRACE ST RENSSELAER, IN 47978

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey date: October 6 & 7, 2015 Facility number: 004199 Provider number: 004199 Census bed type: Residential: 15 Total: 15 Census payor type: Private: 15 Total: 15 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5. Quality review completed by 26143, on October 11, 2015.	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:			

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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	(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports			

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	available for inspection to any member of the public upon request Based on observation and interview, the facility failed to ensure the State Survey results were readily accessible and a notice posted of their availability. This had the potential to affect the 15 residents who resided in the facility. Finding includes: Observations of the facility were completed throughout the survey process from 10/6/15 - 10/7/15. The State Survey results were not observed to be available and there was no sign posted indicating the location of the survey results. Interview with the DON (Director of Nursing) on 10/7/15 at 11:00 a.m., indicated she was aware the survey results were supposed to be accessible. At that time, she pulled an unlabeled binder out of a drawer by the sitting area and indicated the binder contained the survey results.	R 0090	Tag Number R090 State Survey Results State Survey results are maintained in a binder located in the common area of the facility. The binder was placed in a drawer inadvertently. Binder will now note on its cover the nature of its contents and the need for it to remain in its assigned location. Education provided to staff that survey book must be out and available at all times. Sign posted indicating location of survey results. Binder located on top of cabinet at south end of common area. Director of Nursing will check to assure binder is located properly during monthly rounds for six months, then quarterly for six months and annually thereafter. Completion Date: October 19, 2015 Responsible Party: Debra Ellis, R.N., AlternaCare Director of Nursing	10/19/2015
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure			

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	continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on record review and interview the facility failed to invite the local fire department to participate in a fire drill at least every 6 months. Finding includes: The fire drill records were reviewed on 10/6/15 at 2:41 p.m. Fire drills were completed every month from November 2014 through September 2015. There was not an indication the fire department had been invited at anytime between those dates. Interview with the Facility Director on	R 0092	Tag Number R092 Fire Drill Records Fire drill schedule is produced annually and provided to the local volunteer fire department chief. Local fire department will receive a semi-annual invitation with documentation maintained by both Facilities Director and Administrator. 2015 schedule resubmitted to fire chief. Administrator and Facility Director will place an automated calendar reminder for every six months to invite fire department to attend drills. Completion Date: October 8, 2015 Responsible Party: Mike Bayci, H.F.A., Administrator	10/08/2015

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	10/7/15 at 10:38 a.m., indicated he could not find any documentation the fire department had been invited since last year.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained			

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	and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure the required 6 hours within 6 months of hire and 3 hours of annual dementia training were completed for 3 of 5 licensed staff members. (RN #1, CNA #1, and CNA #2) Finding includes: Review of facility staff personal files on 10/6/15 at 2:00 p.m., indicated RN #1 was hired on 7/21/14. The personal file lacked any indication the staff member completed the required 6 hours within 6 months of hire dementia training. The personal files lacked indication CNA #1 and CNA #2 had completed the required 3 hour annual dementia training for the calendar year 2014. Interview with the Director of Nursing (DON) on 10/7/15 at 8:50 a.m., indicated she was unable to find any documentation the employees had received the required hours for dementia training.	R 0120	Tag R120 Inservice Education Education and documentation of completion will be obtained for the three (3) employees lacking training. All current departmental employee records will be reviewed to assure training has been obtained. Newly hired Education Coordinator will retain documentation of employee written signature when six (6) hours of dementia training is completed after hire; and three (3) hour dementia training yearly thereafter is completed. Annually, Director of Nursing will review documentation maintained by Education Coordinator. Completion Date: November 9, 2015 Responsible Party: Debra Ellis, R.N., AlternaCare Director of Nursing	11/09/2015

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R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain a state of cleanliness and good repair related to gouged and chipped walls and corners and rusty faucets in 2 of 5 resident rooms observed and a brown stain on main the hallway ceiling. (Rooms 216 & 220, main hallway ceiling) Findings include: An environmental tour was conducted on 10/7/15 at 10:45 a.m. with the Facilities Director. At the time of the tour, the following were noted: 1. There was a brown circular stain on the ceiling in the main hallway between Rooms 204 & 206. 2. The walls behind the recliner and next to the bed in Room 216 were gouged, the paint on the bathroom door jamb was chipped and peeling, and the faucet was	R 0144	Tag Number R144 Sanitation and Safety StandardsFacility Director and staff toured the facility and made a comprehensive list of repairs. Facility Director has established a quarterly room inspection checklist to prevent future occurrences. This list will be provided to Administrator after each quarterly inspection.Completion Date: November 1, 2015Responsible Party: Kevin Trusty, Facilities Director	11/01/2015

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	green and rusty. One resident resided in this room. 3. The walls behind the bed in Room 220 were gouged and the paint on the bathroom door jamb was chipped and peeling. One resident resided in this room. At the time of the tour, the Facilities Director indicated all areas were in need of repair.			
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, interview, and record review, the facility failed to maintain equipment and supplies in a safe and operational condition related to improper bed rail gaps for 13 of the 15 occupied resident beds in the facility. Finding includes: During a resident interview and room observation in Room 216 on 10/6/15 at 10:25 a.m., the bed was noted to have side rails attached which had two large gaps between the separator bars within	R 0145	Tag Number R145 Bed Rails Bed rail retrofit kits have been ordered and will be installed on all beds once received. All beds in facility and storage will be reviewed to determine if they meet the standards. Kits will be applied to all beds failing to meet standards or beds will be removed from facility. Photographs of each bed style with kit in place is included with plan of correction addendum. Kits lock in place and require tools to remove. Beds failing to meet entrapment standards will not be purchased	11/16/2015

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	the rails. At that time, the resident indicated the 2 top rails were usually raised by staff when he was in the bed. A follow up observation of the bed rails on the bed in Room 216 at 11:00 a.m. the bed rail gaps were measured. The vertical space between the top of the rail opening and the bottom of the rail opening measured 7 3/4" high. The horizontal distance between each of the vertical rail support bars measured 6 3/4" wide. During a facility-wide bed rail check tour with the DON on 10/6/15 at 12:20 p.m., three different types bed rails were found on 13 of the 15 occupied resident beds. Bed rail type 1, as described on the bed in Room 216, was found on the following beds: 206, 208, 210, 216, and 220. Bed rail type 2 was noted to have three large gaps, all measuring roughly 7 1/2" high by 7 3/4" wide. This bed rail was found on the beds in the following rooms: 201, 203D, 205, 212, and 218. Bed rail type 3 was noted to have one large gap mid-rail. The gap measured 7 1/2" high by 7" wide. This rail was found on the following beds: 202, 204 and 214. At the time of the tour, the DON indicated all of the residents using the above beds usually had the top two rails pulled up by staff when they were in the bed. She further		in the future. New beds on market meet current entrapment standards. Completion Date: November 16, 2015 Responsible Party: Kevin Trusty, Facilities Director	

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	indicated there was no facility bed rail policy. Review of the resource "Summary of FDA Hospital Bed Dimensional Limit Recommendations" indicated the Zone 1 "Within the rail" Dimensional Limit Recommendations were a gap of < (less than) 4 3/4" in both directions (high and wide).			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to complete a laboratory test as ordered by the Physician for 1 of 5 residents whose records were reviewed. (Resident #3) Finding includes: Resident #3's record was reviewed on 10/6/15 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, Alzheimer's Disease,	R 0241	Tag Number R241 Health Services All resident lab tests are now being reviewed during shift report with pending labs and test results discussed. Present process will be evaluated resulting in new policy and procedure for processing orders and reviewing laboratory values to assure all orders are processed in a timely manner. Once policy and procedure is developed, all licensed staff will be educated on the process and at the next staff meeting. Procedure AC-11 Nursing Orders	11/19/2015

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	depression and psychosis. Review of the October POS (Physician Order Summary) indicated the following laboratory orders: - A1C (a test to measure blood sugar control over the past 2-3 months) every 3 months - CBC (complete blood count), BMP (basic metabolic panel) every month - FBS (fasting blood sugar) every month Review of Resident #3's laboratory results indicated A1C levels were done on 9/29/15 and 6/29/15. The record lacked documentation of an A1C level completed in March 2015. Interview with the DON (Director of Nursing) on 10/7/15 at 8:50 a.m., indicated she had spoken to the lab and there was no documentation to indicate an A1C level was completed as ordered in March 2015 and she was unsure why it had not been done.		on Treatment Cardex revised with addition of item number 9. Policy is attached to plan of correction addendum. Director of Nursing will monitor new process weekly for three months, monthly for three months and quarterly for six months. Completion Date: November 19, 2015 Responsible Party: Debra Ellis, R.N., AlternaCare Director of Nursing	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling			

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	standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to store and prepare foods in accordance with safe food handling standards related to the use of non-pasteurized eggs and improper sanitation of the food temperature probe during food temperature monitoring. This had the potential to affect the 14 facility residents who receive food from the kitchen. Findings include: 1. During an observation of the kitchen on 10/6/15 beginning at 9:05 a.m. with the Dietary Director, the following was observed: a. There was a large carton of non-pasteurized eggs in the walk in dairy refrigerator. During an interview with the Dietary Director at the time of the observation, he indicated he was unaware the shell eggs had to be pasteurized. 2. During an observation of lunch food temperature monitoring on 10/6/15 beginning at 11:10 a.m. with the Dietary Director, the following was observed: The Dietary Director wiped off the	R 0273	Tag Number R273 Food and Nutritional Services All egg products, including shell eggs, will be pasteurized and purchased as such. Vendor has removed non-pasteurized eggs from order screen for facility. Dietary Director has amended policy and is responsible for ordering and intake of foods and will be able to verify only pasteurized shell eggs are ordered and received. Dietary Policy V-16, Purchasing and Service of Eggs, will be revised to reflect this change. Policy will be reviewed with Dietary Department staff at next staff meeting. When checking food temperatures on patient/resident tray line and the Cafeteria, the thermometer will be sanitized before and after tray line and the probe will be cleaned between checking each individual food item. Dietary Policy V-15, Monitoring of Food Temperatures for Patient/Resident and Cafeteria Service, will be revised to reflect this change. Policy will be reviewed with Dietary Department staff at next staff meeting. Completion Date: November 6, 2015 Responsible Party: Jay Covill, R.D., Dietary Services Director	11/06/2015

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	temperature probe with a sterile probe wipe and then proceeded to test the temperature of the food in serving dishes on the steam table. He first tested the green beans, then tapped the probe against the side of the dish, placed the probe directly into the squash, tapped the probe against the side of the dish to remove the food residual, place the probe directly into the cream of chicken soup, tapped the probe on the side of the dish to remove the residual, then place the probe directly into the ham and beans, at which time the probe stopped working and was set aside. Interview of the Dietary Director at the time of the observation, indicated "sometimes I wipe the probe off between foods and sometimes I don't." Cook #1 then proceeded to grab another temperature probe and test the ham and beans without cleaning it off prior, then placed it on the back sink. She then retrieved the same probe and inserted it into the pot pies, then directly into the pureed cornbread, then the pureed ham and beans, at no time visibly cleaning the temperature probe. Interview with Cook #1 at the time of the observation, indicated she had washed the probe off prior to testing the first			

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	temperature, but not between foods. A policy titled "Monitoring of Food Temperatures for Patient/ Resident and Cafeteria Service" was provided by the Dietary Director on 10/6/15 at 1:50 p.m. The policy indicated, ".... A calibrated thermometer will be used to check food temperatures. Just prior to checking temperatures and immediately after checking temperatures, the thermometer needs to be cleaned and sanitized by wiping with an alcohol pad. The alcohol needs to dry before checking temps ...."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review and interview, the facility failed to maintain	R 0349	Tag Number R349 Clinical Records Physician order obtained immediately for	10/19/2015

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FRANCISCAN HEALTH ALTERNACARE	1104 E GRACE ST RENSSELAER, IN 47978

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	clinical records that were complete and accurate related to lack of a physician's order and documentation for wound care for 1 of 5 residents reviewed for clinical records in the sample of 5. (Resident #2) Finding includes: On 10/6/15 at 10:54 a.m., Resident #2 was observed sitting in a recliner in her room. Her feet were elevated and the bottom of her left leg was wrapped in gauze. Record review for Resident #2 was completed on 10/6/15 at 10:21 a.m. The residents diagnoses included, but were not limited to, dementia, hypertension, and anxiety. A Nurse's Note dated 8/21/15 at 9:40 a.m., indicated the resident had a fall from her recliner. The resident had a 5 inch long by 3 inch wide hematoma (collection of blood underneath the skin) to the bottom of her left leg. An ice pack was placed onto the leg. At 11:00 a.m., the hematoma split open and started leaking blood. A sterile gauze was placed on the split. The physician was called and the resident was sent to the hospital. A Hospital Emergency Room (ER) Visit		Resident #2. All resident wound care will have a physician order. Documentation of care provided will be noted in the medical record. Wound care with staff sign-off is now included on the Medication Administration Record (MAR). AlternaCare Director of Nursing will routinely monitor this information weekly for three months, monthly for three months and quarterly thereafter. Completion Date: October 19, 2015 Responsible Party: Debra Ellis, R.N., AlternaCare Director of Nursing	

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	sheet indicated the resident was seen in the ER on 8/21/15. The orders were to leave the dressing on for 48 hours, then dress the wound every day. Review of the October 2015 Physician Order Summary (POS) lacked an order for dressing changes to the resident's leg wound. Review of Nurse's Notes from 8/21/15 through 10/4/15 lacked any indication the leg wound dressing was changed on the dates: 8/25/15, 8/28/15, 8/30/15, 9/4/15, 9/5/15, 9/10/15, 9/12/15, 9/13/15, 9/14/15, 9/16/15, 9/18/15, 9/21/15, 9/22/15, 9/23/15, 9/25/15, 9/26/15, 9/27/15, 9/28/15, and 9/30/15. Interview with the Director of Nursing (DON) and LPN #1 on 10/6/15 at 10:54 a.m., indicated when the resident came back from the hospital the dressing was to be changed everyday. They indicated they had spoke with the doctor but did not put an order into the resident's treatment record for the dressing changes. LPN #1 indicated since the wound had been improving they decided to do the dressing changes every other day instead of daily, but did not put an order for the dressing changes into the resident's treatment record. She indicated this change was made approximately 2 weeks			

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	ago. LPN #1 indicated the only documentation to indicate the wound treatments are being completed is in the Nurse's Notes. The DON further indicated a physician's order should have been put into the resident's treatment record and the nurses should have been documenting each time the dressings were changed. A follow up interview with LPN #1 on 10/6/15 at 11:40 a.m., indicated she had spoken with the physician and received a new order to change the dressing to the left leg wound daily until healed. She further indicated the physician's order would be put into the resident's treatment record.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.			

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	(6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to maintain a complete emergency file on a resident related the absence of a resident's picture. (Resident #5) Finding includes: Resident #5's record was reviewed on 10/6/15 at 10:10 a.m. Diagnoses included, but were not limited to, depression, asthma, anemia. anxiety, congestive heart failure The resident's emergency file in the emergency binder was reviewed and lacked a picture of the resident. Interview with the DON (Director of Nursing) on 10/6/15 at 10:15 a.m., indicated each resident emergency file should include a picture of the resident.	R 0356	Tag Number R356 Clinical Records A photograph of each resident will reside in the Emergency File. A photograph of Resident #5 was immediately placed in Emergency File during survey. Photographs will be secured in file to prevent them from falling out of the file. AlternaCare Director of Nursing will ensure photograph is placed upon admission. Emergency File binder will be reviewed monthly by Director of Nursing going forward. Completion Date: October 8, 2015 Responsible Party: Debra Ellis, R.N., AlternaCare Director of Nursing	10/08/2015
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the			

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	development and transmission of diseases and infection. Based on observation, record review, and interview the facility failed to ensure an infection control program was maintained related to the improper storage of a nebulizer mask (delivery device used to administer medication in the form of mist inhaled into the lungs) for 1 of 3 residents reviewed for inhalant medications in a sample of 5. (Resident #6) Finding includes: On 10/6/15 at 3:45 p.m., a nebulizer mask was observed uncovered laying on a paper towel on Resident #6's night stand. On 10/7/15 at 8:58 a.m., a nebulizer mask was observed uncovered laying on a paper towel on Resident #6's night stand. Record review for Resident #6 was completed on 10/7/15 at 9:02 a.m. The residents diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), emphysema, dementia, and hypertension. Review of the October 2015 Physician Order Summary (POS) indicated the resident received Albuterol Sulfate	R 0406	Tag Number R406 Infection Control Policy and procedure will be created for nebulizer treatments to include management and care of equipment. Staff education on policy and procedure will occur immediately and at the next staff meeting. Procedure 02 Changing Disposable Equipment created and attached to plan of correction. Compliance with new policy will be monitored by Director of Nursing weekly for three months, monthly for three months and quarterly thereafter. Completion Date: November 19, 2015 Responsible Party: Debra Ellis, R.N., AlternaCare Director of Nursing	11/19/2015

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	(respiratory medication) 2.5 mg (milligrams)/3 ml (milliliters) solution. The order indicated to inhale 3 ml by nebulizer every 6 hours for COPD. Interview with the Director of Nursing (DON) on 10/7/15 at 9:05 a.m., indicated the last nebulizer breathing treatment the resident received was at 3:00 a.m., and the mask should have been put into a bag since then.			