STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	950 N LAKEVIEW DR GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 a Recertification and State Licensure survey. Dates of survey: February 20, 21, 22, and 23, 2012 Facility number: 011039 Provider number: 155675 AIM number: 200299100 Survey team: Diana Sidell RN, TC Cheryl Fielden RN Jill Ross RN Janie Faulkner RN Census bed type: SNF: 26 SNF/NF: 19 Residential: 23 Total: 68 Census payor type: Medicare: 9 Medicaid: 17 Other: 42 Total: 68 Sample: 12 Residential sample: 7 These deficiencies also reflect state	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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	findings cited in accordance with 410 IAC 16.2. Quality review completed 2/28/12 Cathy Emswiller RN			

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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. A. Based on record review and interview, the facility failed to administer a	F0441	**F 441** 1. A. There was no negative outcome to resident	03/12/2012

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	tuberculosis Mantoux test in a timely manner in that the 1st step tuberculosis Mantoux test was administered six days after admission. This affected 1 of 12 residents reviewed for tuberculosis Mantoux test in a sample of 12. (Resident # 10) (Director of Nursing) B. Based on observation, record review, and interview the facility failed to properly clean and store a nebulizer mask, tubing, reservoir and other equipment used during a respiratory treatment, for 1 of 2 residents observed for nebulizer treatments during medication pass. (Resident # 21) (Employee # 3/RN) C. Based on observation, the facility failed to ensure nurses followed proper infection control procedures, in that one nurse took a soiled tissue from resident with an ungloved hand and another nurse laid a soiled glucometer on top of the medication cart and drew up insulin with unwashed hands. This affected 2 of 4 residents observed during two medication passes. (Resident # 46 and # 21) (Employee # 3/RN and Employee # Employee # 2/LPN) D. Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a		#10. Resident #10 completed the two step TB skin test process with results of 0.00mm /negative. Licensed nursing staff have been re-educated regarding admission TB skin test regulation and action in the event of resident refusal. **(See attachment A).** B. There was no negative clinical outcome to resident #21 from the alleged deficiency. RN #3 has been re-educated regarding appropriate infection control practices during administration of nebulizer therapy. The policy pertaining to administration of aerosol treatments has been revised to include cleaning of equipment prior to storage. **(See attachment A).** Licensed nursing staff have been re-educated regarding appropriate hand hygiene, nebulizer therapy infection control, and infection control practices including wearing gloves for handling items soiled with body fluids. **(See attachment A).** C. There was no negative clinical outcome to resident #46 or resident #21 from the alleged deficiency. Nurse #3 and nurse #2 have has been re-educated regarding appropriate infection control practices including disinfection of blood glucose meter prior to placement on the medication cart and performing hand hygiene prior medication preparation/injection. **(See attachment B).** D. Staff has been reeducated regarding performing hand hygiene before	

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	safe, sanitary and comfortable environment to help prevent the transmission of disease and infection in that staff failed to wash their hands after contact with the residents before serving food. This affected 1 of 2 dining room observations for 4 of 28 random observations of residents during meal service. Findings include: A. On 2/22/2012 at 3:18 P.M. the record review of Resident # 10, indicated the resident was admitted on 2/10/2012 with diagnoses that included, but were not limited to abdominal wound infection; colostomy; post-operative GI bleed with large gastric ulcer; post-operative encephalopathy; and hypertension. Review of "IMMUNIZATION RECORD/TB SCREENING/RISK ASSESSMENT", provided by the Director of Nursing on 2/22/2012 at 4:15 P.M., indicated resident # 10 received her 1st step tuberculosis Mantoux test on 2/16/12. There was no information in any of the nurses notes or on the admission assessment that resident # 10 refused the tuberculosis Mantoux test the day of admission. During an interview with the Director of Nursing on 2/22/2012 at 4:17 P.M., she		each resident contact. The DON or designee is monitoring the dining experience to assure appropriate hand hygiene and handling of drink glasses during the dining service. **(See attachment C). 2.** A. All resident admissions have the potential to be effected by the alleged deficiency. All new admissions will be monitored to assure initial TB skin test is administered prior to or upon admission unless the person has a history of positive TB skin test result. All Licensed Nurses were re-educated by DON/Designee for following facilities policy and procedure regarding TB skin test upon admission. **(See attachment A)** B. All residents receiving aerosol nebulizer therapy have the potential to be affected by the alleged deficient practice. The policy pertaining to administration of aerosol treatments has been revised to include cleaning of equipment prior to storage. **(See attachment D).** Licensed nursing staff have been re-educated regarding appropriate hand hygiene, nebulizer therapy infection control, and infection control practices including wearing gloves for handling items soiled with body fluids. **(See attachment A).** C. All residents receiving injection or medication administration have the potential to be affected. No residents have experienced a negative outcome. Licensed nursing staff have been	

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	stated, she probably refused when admitted as she refused the others, she didn't want to be bothered." "She refused on 2/13/2012, when I asked her and I documented this on the back of her record." B. On 2/21/2012 at 11:55 A.M., during a medication pass observation with Employee # 3/RN, RN # 3 was observed to cleanse her hands with alcohol gel, open med cart and remove vial of Albuterol-IPRAT(Atrovent) 0.5-3(2.5)mg/3ml for nebulizer treatment for Resident # 21. RN # 3 then went to the dining room and asked resident # 21 if she wanted her breathing treatment before lunch, and took hold of Resident # 21's wheelchair and pushed the resident to her room and closed the door. RN # 3 listened to resident's lungs, checked resident's pulse, removed mask, reservoir and tubing from plastic bag on a 3 drawer chest between the two beds and placed medication in the reservoir and connected the reservoir to the mask and tubing and turned on the nebulizer machine. During the treatment RN # 3 stopped treatment to allow resident # 21 to cough secretions into tissue, which RN # 3 took with ungloved hand and laid on the bed. After treatment was completed, RN # 3, placed mask with reservoir with attached tubing		re-educated regarding appropriate infection control practices including hand hygiene, nebulizer therapy infection control, and wearing gloves for handling items soiled with body fluids. D. Residents dining in the main dining room had the potential to be affected. Corrective action includes replacing the hand sanitizer dispenser previously removed from the dining room during renovation. Staff has been re-educated regarding performing hand hygiene before each resident contact. The DON or designee is monitoring the dining experience to assure appropriate hand hygiene and handling of drink glasses during the dining service. **(See attachment E).** 3. A. B. C. Upon hire each licensed Nurse will receive education on Facility's Infection Control Policy and infection control process including hand hygiene and glove use during medication administration, infection control practices during medication administration ,including medication preparation, nebulizer therapy, and blood glucose monitoring. THE DON or designee will monitor to assure to ensure compliance with infection control standards of practice and facility policy. **(See attachment F).** D. The hand sanitizer dispenser previously remove from the dining room during renovation was replaced 2/23/12 to promote	

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	in the plastic bag on the 3 drawer chest between the beds. Tan color secretions were observed in the mask. During an interview with RN # 3 at 12:32 P.M. on 12/21/2012, RN # 3 stated, "I should have rinsed mask and medication reservoir with cold water and shake them until they are dry and then place them in the plastic bag." Review of "POLICY: AEROSOL TREATMENTS" "POLICY NUMBER: 5.14" "ORIGINAL DATE: 03/12/07" provided by the Administrator at 2:00 P.M. on 2/21/2012, indicated, "POLICY: Aerosol (Nebulizer) treatments are administered by a nurse or respiratory therapist per physician order. A nebulized medication inhaled by mouthpiece or mask into the upper and lower airways is delivered to relieve bronchospasm, mobilize secretions, improve sputum clearance and improve pulmonary airflow to decrease the work of breathing." "PROCEDURE: 1. Gather needed equipment...14. Disassemble hand held unit, shake dry and place in plastic bag." Review of the facility "Infection Control Universal Blood and Body Substance Policy with a Date: 4-2-01" provided by the Director of Nursing on 2/21/2012,		hand hygiene. Staff has been reeducated regarding performing hand hygiene before each resident contact and/ or before serving food or drinks. The DON or designee is monitoring the dining experience to assure appropriate hand hygiene and appropriate handling of drink glasses during the dining service. **(See attachment E).** 4. A. New admissions will be reviewed during the daily managers meeting to assure initial TB skin test is completed prior to or the day of admission. B. DON/Designee will monitor administration of nebulizer therapy to assure appropriate infection control practices are implemented, including appropriate use of gloves, appropriate hand hygiene, appropriate cleaning and storage of nebulizer equipment. C. The DON/Designee will monitor Licensed Nurses performances of hand hygiene, glove use and blood glucose meter disinfection. D. DON or designee will monitor to assure appropriate infection control practices during the dining experience, including employees performing hand hygiene between resident contacts, and proper handling of glasses . The DON/Designee will monitor the performance (of B, C, and D) as follows; 5 days per week for two weeks, weekly for four weeks, monthly for two months and at random as	

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	indicated, "PROCEDURE: 1. Universal blood and body substance precautions shall be used in the care of all residents...3. Gloves shall be worn for touching blood and body fluids...and for handling items or touching surfaces soiled with blood or body fluids....". C. On 2/21/2012 at 11:55 A.M., during a medication pass observation with Employee # 3/RN, RN # 3 was observed to cleanse her hands with alcohol gel, open med cart and remove vial of Albuterol-IPRAT(Atrovent) 0.5-3(2.5)mg/3ml for nebulizer treatment for Resident # 21 and go to dining room and ask resident # 21 if she wanted her breathing treatment before lunch, RN # 3 then took hold of Resident # 21's wheelchair and pushed resident to her room and closed the door. During the treatment RN # 3 stopped treatment to allow resident # 21 to cough secretions into a tissue, RN # 3 was observed to take soiled tissue with an ungloved hand and lay tissue on the bed of Resident # 21. On 2/21/2012 at 4:15 P.M., observed Employee # 2/LPN perform a blood glucose check with a glucometer on Resident # 46, then was observed to place the soiled glucometer on top of the medication cart, remove a vial of		needed. Deficient practices will be addressed with the individual immediately by DON/Designee. The results of monitors will be reviewed by the Administrator and the QA team during the quarterly QA meetings. 5. Date of Compliance 3-12-2012	

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	Humalog insulin for Resident # 46 and clean the top of the insulin vial with an alcohol prep pad and draw up insulin with ungloved, unwashed hands. LPN # 2 put gloves on prior to the injection of the insulin, used alcohol prep pad to cleanse an area on right abdomen 2 inches from umbilicus on Resident # 46, and inject 14 units of insulin. LPN # 2 was observed to remove gloves and wash and dry hands. LPN # 2 was then observed to put on clean gloves and clean the soiled glucometer with a antimicrobial bleach wipe and lay it on a clean paper towel on top of the medication cart. D. During a lunch observation on 2/21/2012 from 12:23 p.m. through 12:45 p.m., CNA #1 was observed to touch a residents hair and then served two glasses by grasping the glasses from the top of the glass and then served two plates of food without washing her hands. CNA #1 was then observed to touch a resident's arm twice without washing her hands and continued to serve two more residents their lunch. During an interview on 2/22/2012 at 12:15 p.m., the Dietary Manager indicated that CNA #1 had been educated regarding handwashing prior to serving lunch. A policy and procedure policy titled "Infection Control Universal Blood and			

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	Body Substance Policy" dated 4/2/01 was provided by the Administrator on 2/23/2012 at 9:00 a.m., and indicated, but was not limited to: "...5. Hand hygiene should be performed before and after contact with every resident...." 3.1-18(a) 3.1-18(e) 3.1-18(l)			

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R0300	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on record review, interview and observation, the facility failed to ensure all over-the-counter medications used in the facility were labeled in accordance with currently accepted professional principles and included the expiration date in that medications for residents were not labeled and some were outdated. This affected 2 out of 5 residents in a sample of 5 observed during medication pass. (Residents #51 and 66, and LPNs #1 and 2) Findings include: On 2/20/12 at 7:45 a.m., during medication pass observation with LPN #1, there were 3 bottles of over-the-counter medications without labeling for the specific resident. The manufacturer's directions were different from the physician orders for these three medications. Resident #51 had 1 bottle of Aspirin that was not labeled. Resident #66 had 1 bottle of Aspirin and 1 bottle of Vitamin D that were not labeled.	R0300	What corrective action will be accomplished for those residents found to be affected by the cited deficient practice? Residents #51 and #66 experienced no negative outcome. Morning Breeze staff confirm medication dose prior to administration by confirming the product and dose with the medication Administration Record (MAR) for each medication administered. In addition to resident's name over the counter(OTC's) were labeled with MD name, and dose of medication ordered if different than the manufacturer's label; and audited to assure name of drug, strength of drug , and expiration were on the labels. (See Attachment G)How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All resident's receiving OTC medications or supplements have the potential to be affected. Medications and supplements in the medication cart and refrigerator were audited and assured to be labeled in accordance with current	03/12/2012

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	At the same time as the medication pass observation, upon interview, LPN #1 indicated she would be sure these medications had proper labeling. She said she understood the need for these labels. On 2/21/12 at 8:43 a.m. during the check of the medication room with LPN #2 there was found to be: 2 Bisacodyl Suppositories 10 mg that expired 11/2011. House stock - Complete Ready-to-use Enema expired 12/2011. Gel Rite antiseptic handwash 2 bottles expired 9/2011. Vitamin A&D ointment 1 tube expired 10/2010. 1% Silver Sulfadiazine Cream 1 tube expired 12/2011. Para Pak C&S Kit expired 11/2009. Culture Swab Kits times 5 expired 12/2011. During an interview on 2/21/2012 at 10:50 a.m., LPN #2 indicated all dates should be checked monthly at least.		acceptable standards of practice February 20, 2012. Pharmacy staff audited the medication cart and medication storage areas, February 22, 2012, to assure medications were labeled in accordance with current acceptable standards of practice and inventory contained no outdated medications or OTCs. What measures will be put into place to ensure this practice does not recur? 2/20/12 Licensed nursing staff were educated regarding labeling of OTCs in accordance with current acceptable standards of practice and disposal and documentation of outdated pharmaceuticals. Pharmacy staff will audit the medication cart monthly to assure medications are labeled in accordance with current acceptable standards of practice including monitoring for outdated pharmaceuticals. (See Attachment G) How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Pharmacy staff are contracted to audit medication monthly and report findings to the DON and HFA. The DON or designee will perform quality assurance audits to assure OTCs are labeled in accordance with current acceptable standards of practice. This audit will be completed weekly x 5, every other week x 4, monthly x 4 with immediate corrective action as	

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	During an interview on 2/21/2012 at 9:30 a.m., the Administrator indicated labeling and checking expiration dates for medications and over-the-counters are the responsibility of the pharmacy. She will have her staff checking for these very carefully. "I called our pharmacy and asked they send someone in today to clear this all up." A contract between the pharmacy and the facility was provided on 2/21/2012 at 2:40 p.m. by the Administrator in Training, the contract included but was not limited to, " ...RESPONSIBILITIES OF PHARMACY...(d) label all Pharmacy Products in accordance with Applicable Law..." A policy titled "General Guidelines for Administering Medications" with a revised date of 7/26/06 was provided by AIT on 2/21/12 at 2:00 p.m. The policy included but was not limited to "Standards of practice for medication administration: ...3. If the medication is outdated, remove medication for proper disposal...."		necessary. Results of the OTC label audits will be reviewed by the administrator and presented to the Quality Assurance Committee at least quarterly. (See Attachment H)	

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R0302	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on record review, interview and observation, the facility failed to ensure all over-the-counter (OTC) medications used in the facility were labeled in accordance with currently accepted professional principles in that OTC medications for residents were not labeled. This affected 2 out of 5 residents in a sample of 5 observed during medication pass. (Residents #51 and 66 and LPN #1) Findings include: On 2/20/12 at 7:45 a.m., during medication pass observation with LPN #1, there were 3 bottles of OTC medications without labeling for the specific resident. The manufacturer's directions were different from the physician orders for these three medications. Resident #51 had 1 bottle of Aspirin that was not labeled. Resident #66 had 1 bottle of Aspirin and 1 bottle of Vitamin D that were not labeled.	R0302	What corrective action will be accomplished for those residents found to be affected by the cited deficient practice? Residents #51 and #66 experienced no negative outcome. Morning Breeze staff confirm medication dose prior to administration by confirming the product and dose with the medication Administration Record (MAR) for each medication administered. In addition to resident's name over the counter(OTC's) were labeled with MD name, and dose of medication ordered if different than the manufacturer's label; and audited to assure name of drug, strength of drug , and expiration were on the labels. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All resident's receiving OTC medications or supplements have the potential to be affected. Medications and supplements in the medication cart and refrigerator were audited and assured to be labeled in accordance with current acceptable standards of practice	03/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC		STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240	

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	At the same time as the medication pass observation, LPN #1 indicated she would be sure these medications had proper labeling. She said she understood the need for these labels. During an interview on 2/21/2012 at 9:30 a.m., the Administrator indicated labeling and checking "over-the-counters" are the responsibility of the pharmacy and indicated she will have her staff checking for these very carefully. "I called our pharmacy and asked they send someone in today to clear this all up." A contract between the pharmacy and the facility was provided on 2/21/2012 at 2:40 p.m. by the Administrator in Training, the contract included but was not limited to, "...RESPONSIBILITIES OF PHARMACY...(d) label all Pharmacy Products in accordance with Applicable Law..."		February 20, 2012. Pharmacy staff audited the medication cart and medication storage areas, February 22, 2012, to assure medications were labeled in accordance with current cceptable standards of practice and inventory contained no outdated medications or OTCs. What measures will be put into place to ensure this practice does not recur? 2/20/12 Licensed nursing staff were educated regarding labeling of OTCs in accordance with current acceptable standards of practice. Pharmacy staff will audit the medication cart monthly to assure medications are labeled in accordance with current acceptable standards of practice. (See Attachment G)How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Pharmacy staff are contracted to audit medication monthly and report findings to the DON and HFA. The DON or designee will perform quality assurance audits to assure OTCs are labeled in accordance with current acceptable standards of practice. This audit will be completed weekly x 5, every other week x 4, monthly x 4 with immediate corrective action as necessary. Results of the OTC label audits will be reviewed by the administrator and presented to the Quality Assurance Committee at least quarterly.	

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			(See attachment H)	

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R0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review, interview, and observation, the facility failed to ensure expired medications were properly disposed of after the expiration dates in that outdated medications were observed during 1 of 1 medication room tour. Findings include: On 2/21/12 at 8:43 a.m. during the check of the medication room with LPN #2 the following was observed: 2 Bisacodyl Suppositories 10 mg that expired 11/2011. House stock - Complete Ready-to-use Enema expired 12/2011.	R0306	What corrective action will be accomplished for those residents found to be affected by the cited deficient practice? Residents #51 and #66 experienced no negative outcome. Morning Breeze staff confirm medication dose prior to administration by confirming the product and dose with the medication Administration Record (MAR) for each medication administered. In addition to resident's name over the counter(OTC's) were labeled with MD name, and dose of medication ordered if different than the manufacturer's label; and audited to assure name of drug, strength of drug , and expiration were on the labels. How will the facility identify other residents having the potential to	03/12/2012

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	Gel Rite antiseptic handwash 2 bottles expired 9/2011. Vitamin A&D ointment 1 tube expired 10/2010. 1% Silver Sulfadiazine Cream 1 tube expired 12/2011. Para Pak C&S Kit expired 11/2009. Culture Swab Kits times 5 expired 12/2011. During an interview on 2/21/2012 at 10:50 a.m., LPN #2 indicated all dates should be checked monthly at least. During an interview on 2/21/2012 at 9:30 a.m., the Administrator indicated checking expiration dates for medications and "over-the-counters" are the responsibility of the pharmacy and she will have her staff checking for these very carefully. "I called our pharmacy and asked they send someone in today to clear this all up." A policy titled "General Guidelines for Administering Medications" with a revised date of 7/26/06 was provided by AIT on 2/21/12 at 2:00 p.m. The policy included but was not limited to		be affected by the same practice and what corrective action will be taken? All resident's receiving OTC medications or supplements have the potential to be affected. Medications and supplements in the medication cart and refrigerator were audited and assured to be labeled in accordance with current acceptable standards of practice February 20, 2012. Pharmacy staff audited the medication cart and medication storage areas, February 22, 2012, to assure medications were labeled in accordance with current acceptable standards of practice and assure inventory contained no outdated medications or OTCs. What measures will be put into place to ensure this practice does not recur? 2/20/12 Licensed nursing staff were educated regarding labeling of OTCs in accordance with current acceptable standards of practice and disposal and documentation of outdated pharmaceuticals. Pharmacy staff will audit the medication cart monthly to assure medications are labeled in accordance with current acceptable standards of practice including monitoring for outdated pharmaceuticals. (See Attachment G). How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Pharmacy staff are contracted to audit medication	

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	"Standards of practice for medication administration...3. If the medication is outdated, remove medication for proper disposal...."		monthly and report findings to the DOON and HFA. The DON or designee will perform quality assurance audits to assure OTCs are labeled in accordance with current acceptable standards of practice and disposed of or returned for credit when expired. This audit will be completed weekly x 5, every other week x 4, monthly x 4 with immediate corrective action as necessary. Results of the OTC label audits will be reviewed by the administrator and presented to the Quality Assurance Committee at least quarterly. (See Attachment H).	