

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155368	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2012
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NAME OF PROVIDER OR SUPPLIER TODD DICKEY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 712 W 2ND ST LEAVENWORTH, IN 47137
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: July 9, 10, 11, 12, 13, 2012</p> <p>Facility Number: 000490 Provider Number: 155368 AIM Number: 100291320</p> <p>Survey Team: Carole McDaniel, RN, TC Terri Walters, RN Martha Saull, RN Dorothy Watts, RN 7/9, 7/10, 7/11/12 Vickie Ellis, RN 7/9, 7/10, 7/11, 7/12/12</p> <p>Census By Bed Type: SNF/NF: 63 Total: 63</p> <p>Census By Payor Type: Medicare: 7 Medicaid: 48 Other: 8 Total: 63</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/18/12 by Suzanne</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Williams, RN			

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F0425 SS=G	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on interview and record review, the facility failed to ensure it received medication from the pharmacy at the ordered dose and failed to ensure the medication was administered to the resident at the physician's prescribed dose, for 1 of 1 resident reviewed for a medication incident, resulting in overnight hospitalization of the resident.</p> <p>Resident #62</p> <p>Findings include:</p> <p>The clinical record of Resident #62</p>	F0425	<p>It is the policy of Todd Dickey Nursing and Rehabilitation Center to provide pharmaceutical services, to include procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of the residents. Resident #64 was assessed and sent to ER for evaluation and treatment. The resident was discharged from the hospital to his home, where he currently resides. All residents receiving medications have the potential to be affected by the alleged deficit practice. A one time 100% medication cart audit was completed to identify any</p>	08/03/2012

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	<p>was reviewed on 7/11/12 at 10 A.M. Diagnoses included, but were not limited to, the following: cerebral palsy, quadriplegia, anxiety and depression.</p> <p>During the clinical record review, a physician order was dated 5/21/12 and indicated the following: "Diazepam (Valium) 5 mg (milligrams, dosage measure)/5 ml (milliliters, volume measure) solution:...3 ml (milliliters) tid (three times a day)..."</p> <p>A MAR (medication administration record) dated June 2012 indicated the following: "Diazepam (valium) 5 mg/5 ml solution...give 3 ml ...3 times a day..." Documentation indicated the resident received 3 doses every day of the medication for the month, with the exception of 6/25, where Resident #62 received only one dose of diazepam.</p> <p>A physician communication and progress note, dated 6/25/12, indicated the following: "...instead of 3 mg 3 x (times) daily, he (Resident #62) has been getting 15 mg 3 x day d/t (due to) pharmacy sent Valium Intensol with same instructions."</p> <p>On 7/12/12 at 9:30 A.M., the DON (Director of Nursing) was interviewed.</p>		<p>further mislabeled medications with none noted. Licensed Nurses have been re-educated on facility policy & procedure for medication administration and receipt of medication from pharmacy. Re-education included but was not limited to the 6 rights of medication administration, reconciling medications with the order, label on the box, individual container/bottle, as well as dosing instructions from manufacturer on box. Any medication found to have the above discrepancies will result in non-administration of the medication, pharmacy and DON notification. DON/Designee will perform 3 medication cart audits weekly for two months. Audits will include reconciling medication with physician order, label on medication, label on individual container/bottle and any dosing instructions from manufacturer. Failure to comply with policy and procedure will result in 1:1 re-education up to and including termination. Results of audits will be submitted to the QA committee for further review and recommendations as deemed appropriate. Completion date: August 3, 2012</p>		

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	<p>She indicated the following: The pharmacy sent a box of diazepam solution with a pharmacy sticker placed mostly over the manufacturer's medication identification and concentration information on the front of the box. The pharmacy sticker indicated the following: "Diazepam 5 mg/5 ml solution. Give 3 ml (3 mg)...3 times a day." The DON indicated the documentation on the back of the medication box, indicated the concentration of this medication as 5 mg per 1 ml. She indicated the pharmacy had placed a label with an incorrect concentration of (3 mg per 3 ml) on the front of the box, covering the actual, more concentrated solution of 5 mg per 1 ml. She indicated their investigation of this incident indicated this was a pharmacy error, and the pharmacy accepted their error.</p> <p>During this same interview, the DON provided a photo copy of the back of the box, which has a picture of the dispensing dropper in the bottle. This photo indicated 1 ml (milliliter) of medication was equal to 5 mg (milligrams) of medication. The DON indicated at this time, the actual dropper only had the identifying markings of ml and not the milligram</p>				

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	<p>dose. The DON also provided a photo copy of the end flap of the box, which indicated the box had been opened on 6/22/12. The DON was unsure of the number of doses of this medication the resident received on 6/22/12 from this vial. She indicated the resident received 3 doses of this concentrated medication on 6/23 and 6/24. She indicated the resident received 1 dose of the concentrated medication on 6/25 before being transferred to the hospital for evaluation. She indicated the resident was admitted to the hospital as "observation" status overnight and was discharged home the next day.</p> <p>During this same interview, the DON provided copies of the history and physical of the resident's admission to the hospital on 6/25/12. This documentation included, but was not limited to, the following: "...with cerebral palsy with severe spasticity...According to the patient's adoptive mother, the patient normally is very calm and is able to talk. However, today the patient was very agitated. He has been very restless...The Emergency Room did receive a call...that the patient has been receiving 15 milligrams of valium tid (3 times a day). This was an accidental overdose and the</p>				

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	<p>patient's orders are for him to receive 3 milligrams tid...Assessment: 1. Benzodiazepine overdose 2. Urinary Tract Infection...Plan: It is possible that the patient is having a paradoxical reaction to overdose of Valium and instead of being sedated, the patient is in fact, agitated. Patient also has some mild laboratory indices of urinary tract infection, which could also be playing a role. We will observe the patient and hopefully as the valium comes out of his system, he will become less agitated. We will also treat with Cipro for urinary tract infection..."</p> <p>On 7/12/12 at 11:10 A.M., the DON was interviewed. She indicated the label which pharmacy applies to the bottles/vials sometimes covers the manufacturer label already on the bottle/vial. The DON indicated the nurses would know the dosing instructions from the label, which pharmacy applies to the bottle/vial. The DON indicated because the pharmacy applied label partially covered the manufacturer's label, this is the reason the nurses didn't see the actual concentration on the bottle. The DON indicated when the nurse receives the medications from pharmacy and checks them in, the following is done: the nurses</p>			

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	<p>compares the quantity of each medicine received to the list of medications and quantity received from pharmacy.</p> <p>On 7/12/12 at 2:25 P.M., the DON was interviewed. She indicated on 6/25/12 at 5:45 A.M., the resident had pulled a fingernail off to his right, third digit. She indicated this was not typical behavior for this resident. She indicated the resident's mother was notified of this incident and came in the morning of 6/25/12 to see the resident. The DON indicated the mother requested the resident be sent to the hospital as he wasn't acting normally for himself.</p> <p>On 7/13/12 at 9:15 A.M. a copy of the following drug information was obtained from the facility copy of the 2013 Lippincott's Nursing Drug Guide, which included but was not limited to, the following: drug classes: anxiolytic and benzodiazepine; available forms: oral solution: 1 mg/ml and 5 mg/ml.</p> <p>On 7/13/12 at 9:20 A.M., the DON provided a copy of the facility policy and procedure for "LTC (Long Term Care) Facilities Receiving Pharmacy Products and Services from Pharmacy." This policy was dated</p>			

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	<p>May 2010. This policy included, but was not limited to, the following: "Document any delivery discrepancies (...labeling error...)." At this time also, the DON provided a copy of the "Narcotic count Record" for the resident. This form indicated the Diazepam 5 mg/5 ml was received on 6/14/12. This form also indicated the first dose of this concentration of diazepam was given on 6/22/12 at 6 A.M.</p> <p>On 7/13/12 at 11:20 A.M., the DON was interviewed. She indicated that 90% of the front of the original box was covered by pharmacy labels placed on it. She also indicated that the pharmacy is to notify the facility if a medication is dispensed in a different concentration that was ordered by the physician. She indicated the pharmacy should get clarification of the order before dispensing.</p> <p>On 7/13/12 at 11:30 A.m. the DON was interviewed. She indicated the actual bottle/vial of liquid Valium had a pharmacy label on it but she doesn't know the actual placement of the label as to what was and was not visible. She indicated they disposed of the bottle as it was a narcotic. She indicated the label affixed by the</p>			

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	<p>pharmacy includes the resident name, medication and dosage on the bottle.</p> <p>3.1-25(g)</p>			

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F0469 SS=E	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free of pests at meal times, during meal preparation for 2 of 2 meals observed 1 of 1 meal preparation observed. This affected 8 residents randomly observed in the dining room or in their rooms: Resident # 52, Resident #10, Resident #63, and Resident #7, Resident #47, Resident #70, Resident #28 and Resident #77.</p> <p>Findings include:</p> <p>1. On 7/9/12 at 11:30 A.M., the noon meal was observed in the restorative dining room located in the facility activity room. Four residents at two tables were in the restorative dining room eating with CNA #1 present. These were residents #52, #10, #63, and #7.</p> <p>On 7/9/12 at 11:35 A.M., Resident #52 indicated, flies were on her food. CNA #1 came over to her table and waved her hand back and forth around Resident # 52's food. The fly was then observed on the corner of</p>	F0469	<p>It is the policy of Todd Dickey Nursing and Rehabilitation Center to ensure that the facility maintains an effective pest control program so that the facility is free of pests. No resident showed an ill effect from the deficeint practice.</p> <p>1. In all areas that flies were killed, sanitation practices were used to clean up afterwards.</p> <p>1. The fly that was in the restorative dining room; affecting residents #7, #10, #52 and #63; was killed that day, 7/9/12.</p> <p>2. Resident #28's room was inspected and any flies located were killed, as well as in the dining rooms.</p> <p>3. An inspection was done of each resident room and any flies located were killed.</p> <p>4. The west dining room was inspected and any flies located were killed that affected residents #47 and #70.</p> <p>5. Resident #77's room was inspected and any flies located were killed.</p> <p>6. The kitchen was inspected and any flies located were killed, as well as any utensils that were touched by flies were taken to sanitation areas and cleaned.</p>	08/03/2012	

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	<p>the tablecloth of her table. On 7/9/12 at 11:40 A.M., on this date, Resident #52 indicated she wished the fly would quit bothering her. CNA #1 then asked Activity staff #1 who had come out of her office area of the activity room if staff were allowed to swat flies. Activity staff #1, indicated she would go find out and then exited the room. The fly was then by Resident #63's food and CNA #1 waved her hand back and forth over Resident #63's food. The fly then landed on corner table space beside Resident #63's food. Activity staff #1 returned at this time with a fly swatter and laid the fly swatter down away from the dining tables. She indicated if the fly gets off the resident dining room tables then try to swat it. On 7/9/12 at 11:45 A.M., Resident #52 indicated to staff, that the fly had landed on her hand. CNA #1 then waved her hand back and forth around Resident #52's food. On 7/9/12 at 11:46 A.M., the fly was on table of Residents #63, #52 and #10. Then the fly landed on Resident #63's napkin, and then flew off. CNA #1 at that time indicated to the residents that staff were not allowed to swat at flies around the dining room tables. On 7/9/12 at 11:49 A.M., the fly landed on tablecloth corner beside Resident #63. On 7/9/12 at 11:53</p>		<p>1.A complete walk-thru inspection of all areas of the building was performed to identify locations of flies and problem areas were they were located. This includes resident rooms, hallways, dining areas, shower rooms, activities and therapy, as well as staff only areas. Any flies located in these areas were killed and the area sanitized appropriately.</p> <p>2.On Friday, July 13, the facility had it's pest control provider, Black Diamond, come and assess the situation and take measures to alliviate the fly issue. The pest control applicator sprayed a long acting fly deterrent spray on the outside the building and around the service entrance area and at all entry doors. This practice was again performed on Thursday, July 26. It will be performed monthly, or more often, as needed, during the summer months when flies are present. This service will be evaluated for effectiveness and changes will be made if results are unsatisfactory. All staff have been re-educated on pest control measures within the building, including preventative measures; when, where and how to kill flies; as well as cleaning area after action is taken. We have also re-educated dietary staff on maintaining the door during service deliveries, as well as contact each service delivery person to ensure they understand</p>				

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	<p>A.M., the fly was observed on CNA #1's shoe. Activity staff #1 tried to swat at the fly with the fly swatter a few times and missed. On 7/9/12 at 11:54 A.M., the fly flew over Resident #52's food and the resident was waving her hand back and forth around her food. CNA #1 also started waving her hand across Resident #52's and Resident #63's food. From 12:01 P.M., - 12:03 P.M., CNA #1 continued to wave her hand back and forth between Resident #52 and Resident #63's food to keep the fly from landing on their food. At 12:09 P.M., Resident #7, who was at a different table than Residents #52, #10 and #63, indicated she didn't want that fly around her table. CNA #1 began waving her hand across Resident #7's food.</p> <p>During observation of restorative dining room on 7/9/12 at 12:15 P.M., CNA #1 indicated she had killed the fly.</p> <p>2. During interview with Resident #28 on 7/9/12 at 4:06 P.M., she indicated she was being bothered by flies both in the dining room and in her room.</p> <p>3. On 7/9/12 at 4:22 P.M., a confidential resident interview indicated, "There's another fly in here.</p>		<p>the doors must be closed between loads coming in to the building. We have also cleaned the area around the dumpsters, as well as bleaching out dumpster to remove attractant smells. All bug lights have been cleaned and serviced to ensure proper working order. An air curtain has been ordered and will be installed at the kitchen service entrance to further deflect flies trying to come in the building.</p> <p>3.The administrator/designees will make twice a day rounds and fill out a quality improvement tool to ensure flies are not present. This will be performed daily for two weeks, be re-evaluated and performed at least once daily until fly season is over.</p> <p>4.This cited deficiency will be have a correction date of August 3, 2012.</p>	

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	<p>We just killed one and now another one is in here. That is the way it is here, you just kill one and then another one shows up."</p> <p>4. On 7/11/12 at 12:10 P.M., the noon meal was observed in the west dining room. At this time Resident #47 was observed to have a fly land on her cob of corn . On 7/11/12 at 12:15 P.M., 2 flies had landed on the table near Resident #70's food (different table than Resident #47). The flies were still there at 12:17 P.M., when Resident #70 was observed waving her hand across her food to prevent the flies from landing there.</p> <p>5. On 7/11/12 at 1:50 P.M., Resident #77 was observed to be awake in bed. She was restless, moving her face from side to side, in response to a fly which was persisting in landing on her right lower eye lid. There was another fly on and about her upper torso. There were no staff in the area; however, LPN #6 was at the nurses station. When informed, she was able to obtain a fly swatter and alleviate the problem.</p> <p>6. On 7/12/12 at 11:25 A.M., during kitchen tour, there were two flies traveling around the tray preparation</p>			

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NAME OF PROVIDER OR SUPPLIER TODD DICKEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 712 W 2ND ST LEAVENWORTH, IN 47137		
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	<p>line and landing on plates being used for the meal. One landed on the serving spoon which staff continued to use to scoop corn casserole. Another landed on a tray being sent out which was placed on the steam table.</p> <p>7. On 7/12/12 at 2:30 P.M., the Administrator was interviewed regarding facility's pest control program. She indicated the facility had a monthly visit from the facility's pest control services. She indicated the representative of the pest control program was at the facility last week due to the extreme heat. She indicated the pest control service will also come on an on call basis.</p> <p>On 7/13/12 at 9:15 A.M., a copy of the facility's pest control policy (effective March 2001) was reviewed. This policy included but was not limited : "... Evaluate effectiveness of services and contact pest control agency if additional services are needed."</p> <p>8. On 7/13/12 at 9:50 A.M., the Food Service Manager (FSM) was interviewed regarding the flies in the kitchen. She attributed the prevalence of flies to the recent heat wave. She indicated Tuesdays were the worst for flies entering the kitchen.</p>				

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	<p>Tuesdays were the day of the major dry and refrigeration food inventory deliveries. Deliveries were made through the kitchen door which opened directly into the parking lot where the truck pulled up to the door. The FSM indicated the delivery men were "not good about keeping the door shut between each dolly load they brought in and unloaded." She identified the door which was used. Upon opening it, there was a direct port to the parking lot in which a large solid waste truck was beginning to pump matter from a grease trap not more than 10 feet from the back door. The driver indicated he thought the process was done monthly. The odor throughout the foyer to the kitchen and surrounding parking lot was extremely pungent and malodorous. The FSM, in reference to the waste pumping odor, indicated "we don't want to be back here when this is going on." The kitchen door, which opened directly into the outside in the parking lot, was located a distance of approximately 3 1/2 sedan car lengths from the facility dumpsters.</p> <p>3.1-19(f)(4)</p>			