

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: November 18,19, 20, 21, 22, & 25, 2013</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Survey team: Diana McDonald, RN-TC Melissa Gillis, RN Cheryl Mabry, RN Angela Patterson, RN</p> <p>Census bed type: SNF/NF: 147 Total: 147</p> <p>Census payor type: Medicare: 40 Medicaid: 92 Other: 15 Total: 147</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 06, 2013; by Kimberly Perigo, RN.</p>	F000000	<p>Ms. Kim RhoadesIndiana State Department of Health Long Term Care Division 2 North Meridian Street, Section 4BIndianapolis, Indiana 46204 December 13, 2013 RE: Survey Event ID: DM3D11 Dear Ms. Rhoades: Attached you will find the completed Plan of Correction and attachments for our Annual Recertification Survey dated November 25, 2013. We request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (317)888-4948. Sincerely, Steven Tanner, HFASenior Director</p>	

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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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to respect the resident's dignity in that housekeeper #1 entered the resident's room without having knocked and then spoke to the resident in a demeaning tone of voice.(Resident #61) (Housekeeper #1)</p> <p>Findings include:</p> <p>Observation on 11/18/2013 at 10:30 a.m., while interviewing Resident #203 in her room, Resident #61 (roommate) was taking a bed bath and dropped or knocked something off the bedside table. It sounded like breaking glass. Resident #61 was informed help would be available soon. Surveyor walked across the hall where there was an office and informed staff Resident #61 was taking a bed bath and had knocked something, maybe glass on to the floor. Staff indicated they would call someone. Housekeeper #1 entered</p>	F000241	Resident #61 was interviewed by SSD and validated she thought housekeeper #1 was rude but had not experienced any negative emotional or psychosocial distress. Housekeeper #1 received written PI with emphasis on Kindred Code of Conduct.All residents residing in rooms 118-137 had the potential to be affected. Residents residing in rooms 118-137 were interviewed without further findings of rude behavior.All staff will be in serviced on Kindred Code of Conduct with emphasis on Quality of care and services. Kindred Code of Conduct will continue to be included in Employee Orientation. The ED and DNS will continue to reasonably, monitor staff, resident and/or visitor interaction for inappropriate behaviors and take corrective action to assist in preventing re-occurrences. The IDT will conduct 5 resident, staff and/or family interviews weekly for eight weeks to monitor and ensure residents' rights and dignity are maintained at all times while under our care. Then 40 interviews Quarterly. This will be an on going practice of this	12/25/2013			

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	<p>the room 10 minutes later without knocking or announcing [Gender] self. Housekeeper #1, in a fast pace, loud, unpleasant tone, asked "Where is the glass? Is there glass on the floor in here? Where is it? " Housekeeper #1 found something on the floor and asked Resident #61, "Is this yours., Do you want it?" Resident #61 answered yes and Housekeeper #1 pick up the object and placed it on the bedside table.</p> <p>Interview on 11/18/2013 at 10:40 a.m., with Resident #61 indicated Housekeeper #1 always spoke to [Gender] in this manner. Resident #61 indicated [Gender] thought it was rude.</p> <p>Interview on 11/22/2013 at 11:36 a.m., with DON indicated,"Housekeeping is given customer service training in general orientation. I will get the policy for you."</p> <p>Policy review on 11/22/2013 at 2:00 p.m., indicated facility policy Kindred Healthcare Code of Conduct, "maintain patient/residents' rights and dignity at all times while under our care... Each patient and resident is an individual entitled to dignity, consideration and respect.</p>		<p>facility. Findings from these interviews will be reviewed in Monthly PI meeting and the PI meeting will determine compliance and on going monitoring.</p>				

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	Patient/resident abuse or neglect is not tolerated in any Kindred facility." 3.1-3(t)				

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F000246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>1. Based on interview and record review, the facility failed to reasonably accommodate the shower/bath preference of each individual resident in regard to the number of showers a resident may take per week for 2 of 2 residents reviewed for shower/bath preference. (Resident #67, #78)</p> <p>2. Based on observation, interview, and record review, the facility failed to ensure reasonable accommodations of individual needs and preferences to use the bathroom for toileting, in that the facility failed to have a working and available equipment to assist residents out of bed for 1 of 1 resident reviewed for assist with toileting needs . (Resident #101)</p> <p>Findings include:</p> <p>1. A) Interview on 11/18/2013 at 10:45 a.m., with Resident #78 indicated [gender] wanted to have a shower everyday. [Gender] indicated the facility would allow resident only</p>	F000246	Resident #78 had her shower schedule changed to 5 times a week. Resident #67 had his shower schedule changed to three times a week. C.N.A. # 2 has completed written PI regarding competency for operation of lifts, accommodation of resident needs, and completing maintenance repair slips. Resident #101 continues to use the lift without further incidence for transfers.All residents and / or families were interviewed for their shower preference. Any resident requesting a change in their shower schedule have had their schedule updated to accommodate their preferences. There are 17 lifts in the facility. Maintenance has completed monthly preventative maintenance on all 17 lifts without findings. All residents on C.N.A. #2's assignment for 11/17/2013 were interviewed for any concerns with care.All staff were in-serviced on Activities of Daily Living with emphasis on patients' preferences regarding bathing choices and accommodating their individual needs. All nursing staff was educated on operating	12/25/2013	

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	<p>two showers per week, which was based on the facility's shower schedule. Resident #78 indicated [gender] did not know she could ask for more showers and staff never offered to arrange for more frequent showers.</p> <p>Resident #78's clinical record was reviewed on 11/19/2013 at 10:45 a.m.. Resident BIMs (Brief Interview Mental status) is 13 out of 15, which indicated the resident was cognitively intact and interviewable.</p> <p>Interview on 11/19/2013 at 3:30 p.m., the Nurse Consultant and DON indicate they were not aware of any one wanting a different bathing schedule.</p> <p>Record reviews on 11/20/2013 at 10:46 a.m., Nurse consultant provided the "Preference's of showers," dated 11/19/2013 indicated, Resident #78 indicated [gender] would like 4 to 5 baths per week in the morning.</p> <p>1. B) Resident # 67's clinical record was reviewed on 11/18/2013 at 3:00 p.m.</p> <p>Diagnosis included, but not limited to, cancer, Alzheimer's disease,</p>		<p>Lifts. New residents will be interviewed on admission and readmission for bathing/showering preferences and plan of care adjusted accordingly. The Nursing Managers will follow up with any resident admitted to the facility within 72 hours to validate bathing preferences and coordinate plan of care with the residents' preferences. The IDT will interview residents regarding their bathing preferences during the quarterly and annual care plan meeting. The IDT will complete 40 resident and family interviews quarterly to include resident's choices regarding bathing preferences and concerns related to providing care. All findings from these interviews will be reviewed in monthly PI and the PI committee will determine when 100% compliance is obtained or if further monitoring will continue for six months.</p>		

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	<p>dementia, hyperlipedemia, and depression.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 9/30/2013, indicated, Brief Interview Mental Status (BIMS) is 99. 99 indicated the BIMS could not be assessed.</p> <p>During a family interview with Resident # 67's wife on 11/19/2013 at 3:40 p.m., indicated she would like for Resident #67 to have more showers or baths than two times a week. She indicated Resident #67 has been at the facility for 10 years and even though she has not told the facility that she wished he had more showers, she indicated the facility had never asked whether he wanted more showers.</p> <p>Interview with Director of Nursing (DON) and Nurse Consultant on 11/20/2013 at 9:00 a.m., indicated regarding Resident #67, the facility called his wife and she indicated she would like for Resident # 67 to get three showers or baths a week.</p> <p>On 11/20/2013 at 9:00 a.m., the DON and Nurse Consultant provided the "Preference of Showers", dated 11/19/2013, indicated "Do you</p>				

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	<p>choose how many times a week you take a shower or bath? If No: How many times a week do you get a bath? How many times a week would you like to bathe?...Response: 2X, preference: Tues, Thur, Sat."</p> <p>2. On 11/19/13 at 10:43 a.m., interview with Resident #101 indicated, "It takes a long time to get call light answered. Last Sunday night I had to go to the bathroom and no one could find the stand up lift that worked to take me to the bathroom. They never found a lift that worked and offered me a bedpan that I couldn't use. [Name] told me she couldn't find it, so I just waited until the next morning to use the bathroom when day shift came on."</p> <p>Resident # 101's clinical record was reviewed on 11/25/13 at 3:30 p.m.</p> <p>Diagnoses included, but not limited to seizure, DM (diabetes), CVA (cerebral vascular accident), anxiety, and depression. The current MDS (Minimum Data Set) assessment dated 8/22/13 indicated, Resident #101 was "extensive assist of one staff person for toileting, ... extensive assist of two staff for transfer." The current BIMS (brief interview mental status) dated 8/22/13 indicated a score of</p>			

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	<p>15 out of 15, when 8 was interviewable.</p> <p>On 11/25/13 at 8:30 a.m., interview with Sycamore's Unit Manager, when asked if the stand up lifts had been broken, indicated, "I was not aware of any stand up lift not working. If there were problems it is to be written on the log. Nothing on logs of a broken one." When asked how many body lifts were in the facility indicated, "I don't know about the facility, I just know Sycamore had two."</p> <p>On 11/25/13 at 8:40 a.m., interview with Maintenance #1 when asked how often are the standup lifts receive maintenance indicated, "Monthly, I have the logs. No one reported to me of having a problem." When asked how many body lifts were in the facility indicated, "three."</p> <p>On 11/25/13 at 4:43 p.m., interview with CNA #2 (certified nursing assistant) (CNA who provided care to Resident #101 last Sunday) indicated, "I went to answer call light, then I went to get stand-up lift, neither were working. The one legs were stuck open and the other had the arms raised up and couldn't get down. I went to change the battery, but it still didn't work. I went to the room and offered the bedpan and [gender] said I can't use bedpan. I explained I don't know what else to do. Then [gender] said</p>			

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	<p>that's ok, I don't have to use it." When CNA #2 was asked who did you inform that the stand-up lifts aren't working. CNA #2 indicated, "my nurses were standing and watching me try to get the lifts to work. That was my fault for not making a maintenance report. I didn't tell anyone. I felt [gender] said [gender] didn't have to use it anymore. When the day shift CNA came on [gender] changed the battery and it worked. That's what happens, sometimes it works and sometimes it doesn't." When asked how many body lifts were in the facility, CNA #2 indicated, "I only know of two."</p> <p>Review of documents received on 11/25/13 at 11:21 p.m., from the DON (director of nursing) with no label and dated January - December 2013 indicated, the body lift machines were maintenance monthly without any indication of problems.</p> <p>3.1-3(v)(1)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to revise a care plan with appropriate interventions to prevent an accident in 1 of 2 resident's reviewed for accidents in a sample of 2 who met the criteria for accidents. (Resident #244)</p> <p>Findings include:</p> <p>On 11/21/2013 at 10:45 a.m., the clinical record was reviewed for Resident #244.</p>	F000279	Resident #279's care plan has been updated to include revised interventions to prevent an accident related to factors that place resident at risk. All residents have the potential to be affected. An audit has been completed of all residents' care plans to validate appropriate interventions to prevent an accident have been included in the care plan. All Licensed Nurses have been educated on Care Plans with emphasis on the plan of care is developed on the patient's individual needs as identified by assessments. The DNS/Designee will review the care plan of all	12/25/2013	

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	<p>Diagnosis included, but were not limited to, Alzheimer's, ischemic heart disease, osteoarthritis, and hypertrophy prostate without urinary obstruction.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 10/25/2013 assessed Resident #244's BIMS (brief interview of mental status) as a 2 out of a score of 0-15. This score indicated, his cognitive status was severely impaired, and not interviewable.</p> <p>The CAA's (Care Area's Assessment) assessed on the MDS included but were not limited to, cognitive loss, dementia, urinary incontinence, and falls. The assessment indicated he was a extensive assist of one person for transfer, locomotion on unit, and toilet use. The assessment indicated, he needed mobility devices such as walker or wheelchair.</p> <p>On 11/19/2013 12:35 p.m.,an interview with Unit Manager for the Reflections Units indicated, Resident #244 fell on 11/2/2013, at that time she indicated, he fell and obtained a skin tear to his right elbow.</p> <p>A nursing progress note dated</p>		<p>residents with an accident weekly to verify the care plan included interventions related to risk factors and that the care plan is revised with interventions to prevent an accident for 3 months, then Quarterly and with significant change for three months. All findings will be reviewed in monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if on going monitoring will be required.</p>				

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	<p>11/2/2013 at 7:01 a.m. indicated, "...Resident partially incontinent on floor and finished in toilet. CNA assisted resident off toilet and resident slipped and fell onto buttocks in floor. Resident did not hit head. No redness, swelling or bruising noted. Resident did have 1.5 X 3 cm skin tear to R [right] elbow. Area cleansed. Bacitracin applied and covered with band-aid..."</p> <p>At that time a post fall evaluation was conducted and it indicated, Resident #244 had bed alarm, and chair alarm. He was brought to common area for supervision.</p> <p>A care plan dated 10/18/2013 and revised on 10/25/2013, indicated he was high risk for falls related to confusion, poor communication/comprehension, gait/balance problems, falls risk assessment score, diminished safety awareness and diagnosis of dementia. The post fall revision of interventions dated 11/04/2013 indicated, do not leave Resident #244 unattended in restroom. The care plan lacked documentation to indicate an updated intervention related to the cause of the fall.</p> <p>On 11/25/2013 at 3:50 p.m., policy on</p>						

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	<p>"Accidents and Supervision to Prevent Accidents" dated 08/31/12 was provided by the Nursing Consultant, and indicated the policy was the one currently used by the facility. The policy indicated,</p> <p>"12. If the CAA for falls, cognitive loss/dementia,...are triggered, use those CAA's to assess causal factors for decline or lack of improvement. ...b. Care plan and implement preventive measures for the patient at risk for falls."</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure hydration monitoring was implemented as indicated by the care plan for 1 of 2 residents reviewed for hydration in a sample of two that met the criteria for hydration. (Resident #74)</p> <p>Findings include:</p> <p>Resident #74's clinical record was reviewed on 11/21/13 at 12:06 p.m.</p> <p>Diagnoses included, but not limited to: acute respiratory failure, muscle weakness, pressure ulcer stage 2, dementia, delusional disorder, CHF (congestive heart failure), anxiety, backache, arthropathy site, neuropathy, myalgia, and myositis.</p> <p>Resident #74's medications included: Seroquel 50 mg bid (twice a day) drug classification (antipsychotic), which has an adverse effect of dry mouth, Lasix 40 mg daily is a diuretic (water pill).</p>	F000282	Resident # 74's care plan for hydration has been updated. PI has been completed with the Licensed Nurse developing the care plan for resident #74. All residents with a care plan for Intake measurement are at risk. An audit of all residents' care plans has been completed and any resident with a care plan for intake monitoring has monitoring in place. All nursing staff has been educated on Fluid Intake and Output Measurement with emphasis on recording Intake and Output. All Licensed nurses have been educated on Care Plans with emphasis on implementing care plan interventions. The DNS/Designee will review the care plan of all residents with an intervention requiring intake monitoring to validate intake monitoring is implemented weekly in the resident at risk meeting. The Intake and Output record will be initialed five times a week by the DNS/Designee to verify intake is monitored for one month, then three times a week for one month, then twice a week for one month, then weekly for three months. All findings will be reviewed in monthly PI and the PI	12/25/2013			

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	<p>Resident #74's current BIMS (brief interview mental status) dated 9/16/13, indicated a score of 14 out of 15, when 8 was interviewable. The current MDS (Minimum Data Set) assessment dated 9/16/13 indicated, Resident #74 was supervision with cueing for eating (this includes fluid intake) and assist of one staff person.</p> <p>On 11/19/2013 at 2:38 p.m., Resident #74 indicated, when asked if fluids were offered between meals, "Not on night shift."</p> <p>On 11/22/13 at 9:30 a.m., interview with Sycamore's Unit Manager indicated, when asked how do you monitor if residents are receiving fluids in between meals "People that are not on thicken liquids, the cup of water is dated and the CNA's take a ice bucket around and go room to room passing water, once a shift, and as needed per residents request. Night shift originate cups for the next day. Everyone gets water passed except for fluid restriction residents, the CNA's would check with nurse first. I have not had any complaint of fluids not being passed on weekends nor night shift. We don't track I & O (intake and output) unless resident at risk for dehydration."</p>		committee will determine when 100% compliance is achieved or if on going monitoring is required.	

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	<p>Review of careplan dated 9/4/13 received from Dietician on 11/22/13 at 10:10 a.m., indicated, "Resident has potential for dehydration or potential fluid deficit r/t (related to) Poor intake, Diuretic (water pill) uses. Intervention... Ensure resident access to regular type and consistency fluids i.e. (and) cold water, thickened apple sauce whenever possible. date initiated 9/4/13, Invite resident to activities that promote additional fluid intake. Offered drinks during one-to-one visits. Ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements initiated 9/4/13, Monitor and document intake and output as per facility policy."</p> <p>Review of documentation on 11/25/13 at 1:53 p.m., labeled "COMPREHENSIVE INTAKE-OUTPUT RECORD [I & O]" indicated, 9/2/13 -9/8/13, resident was monitored for I & O. 9/12-9/28, but not all shifts were documented nor was intake according to estimated total fluid needs and no documentation noted for October 2013- to present. (A total of 27 missing notations for the month of September, 93 missing notations for the month of October and 75 missing notations for the month of November).</p>						

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	<p>Review of documentation, "Medical Nutrition Therapy Assessment" current and effective date 8/29/13 received from ADON (assistant director of nursing) on 11/25/13 at 2:55 p.m., indicated, " ... G3f. Total fluid estimated needs 1575-1900" calculated milliliter of fluid requirement per day.</p> <p>Review of facility policy labeled "Hydration" dated 10/31/10 received from the ADM (Administrator) on 11/21/13 at 9:10 a.m., indicated, "... Sufficient Fluid the amount of fluid needed to prevent dehydration (fluid output far exceeds fluid intake) and maintain health. The amount needed is estimated for each resident, and fluctuates as the resident's condition fluctuates. ...3. Nursing center staff offers residents a variety of beverages and alternative fluid sources (e.g., popsicles, gelatin, ice cream, etc.) throughout the day unless contraindicated by physician orders (i.e., fluid restriction) and/or by clinical condition (i.e., congestive heart failure, renal failure) as assessed by the Registered Dietitian or Licensed Nurses. 4. Fluids are offered at the following opportunities unless contraindicated, but limited to: meals, in-between meals, ... at</p>			

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	<p>resident request, if applicable, 5. Water is provided at beside unless contraindicated ..."</p> <p>Review of facility policy labeled "Fluid Intake and Output Measurement" original date 12/11/2004, and release dated 9/12/13, received from Sycamore's unit manager on 11/25/13 at 3:05 p.m., indicated "... Patient conditions that require or may require I & O: ... Indwelling Catheters, ... Definitions: Fluid Intake Fluid intake includes oral intake of fluids; ...medications, ... and other fluid installations ...Measuring intake ... 2. Record the amount of oral fluids ingested... Documentation 1. Write the patient's name on the intake and output record. 2. Record the date and time of your shift ...3. Record the total intake ...for each category of fluid for the shift, then total these categories and provide a shift total for intake ..."</p> <p>3.1-35(g)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure that a resident's environment remained free of potential hazards to prevent an avoidable accident for 1 of 2 residents reviewed for accidents in a sample of 2 who met the criteria for accidents. (Resident #244)</p> <p>Findings include:</p> <p>On 11/21/2013 at 10:45 a.m.,the clinical record was reviewed for Resident #244.</p> <p>The diagnosis included, but were not limited to, Alzheimer's, ischemic heart disease, osteoarthritis, and hypertrophy prostate without urinary obstruction.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 10/25/2013 assessed Resident #244's BIMS (brief interview of mental status) score as a 2 out of a score of 0-15. This score indicated, his cognitive status was severely</p>	F000323	Resident #244's care plan has been updated with interventions related to the cause of the fall.All residents sustaining an accident have the potential to be affected. An audit of all residents at risk for an accident have had an audit completed of the care plan validating interventions are updated, current and preventative with related to the cause of the accident.All Licensed nurses have been educated on Accidents and Supervision to Prevent Accidents and care plans. The DNS/Designee will review the care plan of all residents with an accident to validate interventions are implemented and revised five times a week for a month, then three times a week for a month, then twice a week for a month, then weekly for three months. The revised interventions will include preventative measures related to the root cause of the fall/accident and the IDT will observe implementation of interventions across all shifts, including weekends daily for one month , then three times a week for one month , then twice a week for one	12/25/2013

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	<p>impaired, and not interviewable.</p> <p>The CAA's (Care Area's Assessment) assessed on the MDS included, but were not limited to, cognitive loss, dementia, urinary incontinence, and falls. The assessment indicated he was a extensive assist of one person for transfer, locomotion on unit, and toilet use. The assessment indicated he needed mobility devices such as walker or wheelchair.</p> <p>On 11/19/2013 12:35 p.m.,an interview with the Unit Manager for the Reflections Unit indicated, Resident #244 fell on 11/2/2013, at that time she indicated, he fell and obtained a skin tear to his right elbow.</p> <p>A nursing progress note dated 11/2/2013 at 7:01 a.m. indicated, "...Resident partially incontinent on floor and finished in toilet. CNA assisted resident off toilet and resident slipped and fell onto buttocks in floor. Resident did not hit head. No redness, swelling or bruising noted. Resident did have 1.5 X 3 cm skin tear to R elbow. Area cleansed. Bacitracin applied and covered with band-aid..."</p> <p>At that time a post fall evaluation was conducted it indicated, Resident #244</p>		<p>month, then weekly for three months. The results of the audit will be reviewed in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if on going monitoring is required.</p>				

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	<p>had bed alarm, and chair alarm. He was brought to common area for supervision.</p> <p>A care plan dated 10/18/2013 and revised on 10/25/2013 indicated, he was high risk for falls related to confusion, poor communication/comprehension, gait/balance problems, falls risk assessment score, diminished safety awareness and diagnosis of dementia. The post fall revision of interventions dated 11/04/2013 indicated, do not leave Resident #244 unattended in restroom. The care plan lacked documentation of an intervention related to the cause of the accident/fall.</p> <p>On 11/25/2013 at 3:50 p.m., policy on "Accidents and Supervision to Prevent Accidents", was provided by Nursing Consultant and she indicated, the policy was the one currently used by the facility. The policy indicated,</p> <p>"6. Center identifies hazards and risk through which the Center becomes aware of potential hazards in the patient environment and the risk of a patient having an avoidable accident....</p>			

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	<p>12. If the CAA for falls, cognitive loss/dementia,...are triggered, use those CAA's to assess causal factors for decline or lack of improvement. ...b. Care plan and implement preventive measures for the patient at risk for falls".</p> <p>3.1-45(a)(1)</p>			

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F000327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview and record review, the facility failed to ensure that residents had sufficient fluid intake to maintain proper hydration for 2 of 2 residents reviewed for hydration needs in a sample of 2 residents who met the criteria for hydration. (Residents #74 and #171)</p> <p>Findings include:</p> <p>1). Resident #74's clinical record was reviewed on 11/21/13 at 12:06 p.m.</p> <p>Diagnoses included but not limited to: acute respiratory failure, muscle weakness, pressure ulcer stage 2, dementia, delusional disorder, CHF(congestive heart failure) , anxiety, backache, arthropathy site, neuropathy, myalgia, and myositis.</p> <p>Resident #74's medications included: Seroquel 50 mg bid (twice a day) drug classification (antipsychotic), which has an adverse effect of dry mouth, Lasix 40 mg daily is a diuretic (water pill).</p> <p>Resident #74's current BIMS (brief</p>	F000327	<p>Resident #71 has an updated Medical Nutrition Therapy Assessment and dehydration risk assessment completed. The care plan has been revised to reflect the current plan of care and MD and family notified. Resident #171 has an updated Medical Nutrition Therapy Assessment and dehydration risk assessment completed. The care plan has been revised to reflect the current plan of care and MD and family notified. All residents receiving PO hydration have the potential to be affected. All residents receiving PO fluids have had a dehydration risk assessment completed and the RD has completed an assessment of the resident's hydration needs The MD and families were notified of any resident with findings. All staff have been educated on Hydration with emphasis on fluids offered in-between meals and at bedside. The IDT will complete validation of fluids available between meals and at night Q shift x one month, then twice daily for one month, then daily for one month, then twice a week for 3 months. All findings will be reported in monthly PI meeting and the PI committee will</p>	12/25/2013	

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	<p>Review of careplan dated 9/4/13, received from Dietician on 11/22/13 at 10:10 a.m., indicated, "Resident has potential for dehydration or potential fluid deficit r/t [related to] Poor intake, Diuretic (water pill) uses. Intervention... Ensure resident access to regular type and consistency fluids i.e. [and] cold water, thickened apple sauce whenever possible. Date initiated 9/4/13, Invite resident to activities that promote additional fluid intake. Offered drinks during one-to-one visits. Ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements initiated 9/4/13, Monitor and document intake and output as per facility policy."</p> <p>Review of documentation on 11/25/13 at 1:53 p.m., labeled "COMPREHENSIVE INTAKE-OUTPUT RECORD" indicated, 9/2/13 -9/8/13, resident was monitored for I & O. 9/12-9/28, but not all shifts were documented nor was intake according to estimated total fluid needs and no documentation noted for October 2013- to present. (A total of 93 missing notation for the month of October and 75 missing notation for the month of November).</p>						

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	<p>Review of documentation, "Medical Nutrition Therapy Assessment" current and effective date 8/29/13 received from ADON (assistant director of nursing) on 11/25/13 at 2:55 p.m., indicated, " ... G3f. Total fluid estimated needs 1575-1900" calculated milliliter of fluid requirement per day.</p> <p>Review of facility policy labeled "Hydration" dated 10/31/10 received from the ADM (Administrator) on 11/21/13 at 9:10 a.m., indicated, "... Sufficient Fluid the amount of fluid needed to prevent dehydration (fluid output far exceeds fluid intake) and maintain health. The amount needed is estimated for each resident, and fluctuates as the resident's condition fluctuates. ...3. Nursing center staff offers residents a variety of beverages and alternative fluid sources (e.g., popsicles, gelatin, ice cream, etc.) throughout the day unless contraindicated by physician orders (i.e., fluid restriction) and/or by clinical condition (i.e., congestive heart failure, renal failure) as assessed by the Registered Dietitian or Licensed Nurses. 4. Fluids are offered at the following opportunities unless contraindicated, but limited to: meals, in-between meals, ... at</p>				

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	<p>resident request, if applicable, 5. Water is provided at beside unless contraindicated ..."</p> <p>2). Resident #171's clinical was review on 11/21/13 at 12:40 p.m.</p> <p>Diagnoses included but not limited to: DM (diabetes), HTN (hypertension), PVD (peripheral vascular disease), and anemia. The current MDS (Minimum Data Set) assessment dated 10/31/13 indicated Resident #171 was not steady while standing, but able to stabilize without human assist. BIMS (brief interview mental status) 15 out of 15, when 8 was interviewable.</p> <p>On 11/19/13 at 12:49 p.m., Resident #171 interview indicated, "There is no fluids passed on weekends, only during the week."</p> <p>Review of documentation labeled "COMPLAINTS/GRIEVANCES" received 11/25/13 at 10:33 a.m., from the Social Worker dated 11/25/13 indicated, "Res c/o (complained of) [gender] did not get any ice water last weekend... " The facility has not presented a careplan for hydration at this time.</p>			

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	3.1-46(b)			

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the nurse staff data was posted for 3 of 6 days reviewed.</p>	F000356	No residents were harmed. The nurse staff data was posted on 11/25/2013. The Staffing Coordinator has had PI on posting Nurse Staffing Data. The staffing coordinator and nursing administration have been	12/25/2013			

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	<p>Findings include:</p> <p>On 11/18/2013 at 11:15 a.m., an observation of front lobby indicated, the nurse staff data was not posted.</p> <p>On 11/22/2013 at 3:00 p.m., an observation of front lobby indicated, the nurse staff data was not posted.</p> <p>On 11/25/2013 at 12:00 p.m., observation of front lobby indicated, the nurse staff posting was not posted.</p> <p>On 11/25/2013 at 12:00 p.m., an interview with Nursing consultant indicated, she was not sure where the staff posting was, she indicated it was to posted on table in the front lobby. Interview with Executive director at that time indicated, he was unsure of where posting was, he then indicated, the Staffing Coordinator must be updating it.</p> <p>On 11/25/2013 at 12:09 p.m., interview with DON indicated, the Staffing Coordinator was responsible for updating the nurse staff data. She indicated that she would check with her to see why it wasn't posted yet.</p>		<p>educated on Posting Nurse Staffing information. The DNS/Designee will verify the Nurse Staffing Information is posted daily for three months. The DNS/Designee will report any findings to the PI committee monthly in PI meeting and the PI committee will determine when 100% compliance is achieved or if on going monitoring is required.</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained in the kitchen in that food was not labeled properly with open dates, food was not discarded according to facility policy and procedure, covering of open food while on tray in the refrigerator, proper handwashing, dead insects in the overhead lights, and maintaining a clean ice machine. This had the potential to effect 144 of 144 residents served meal from the kitchen.</p> <p>Findings include:</p> <p>On 11/18/13 at 9:00 a.m., during kitchen tour with the DM (dietary manager) observed grits on the shelf with no open date, powder sugar on the shelf with no open date, potato flakes no open date, and decorative sprinkles on the shelf with no open date. There was dice chicken in the freezer with no open date on it.</p>	F000371	<p>No residents were harmed. Food items without open dates were discarded and turkey lunch meat in a baggie was discarded. The ice machine was cleaned by maintenance. The Light fixture with 2 dead roaches was cleaned. The open food on the tray in the refrigerator was covered. The DM, Cook #1, DA, and dietary aide #1 received written PI. 144 residents had the potential to be affected. An audit has been completed of all ice machines, light fixtures, proper labeling with open dates for food, proper discarding of food that was past the use by date and covering of food while on the tray in the refrigerator. All dietary staff have completed a competency for Hand washing and hygiene. ECO pest control has treated the facility. All dietary staff have been educated on Hygiene/Hand washing, Food and Supply Storage Procedure; REFRIGERATED STORAGE, REFRIGERATED STORAGE LIFE OF FOODS, and Procedures related to air drying all food contact surfaces and pest control. Maintenance staff has</p>	12/25/2013			

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	<p>There was turkey lunch meat in a baggies in the walk in refrigerator with a used by date of 11/13. This was 5 days later.</p> <p>On 11/18/13 at 9:15 a.m., white stuff down the side of ice machine, behind and on the floor underneath the machine near employee breakroom and main dining area. DM indicated, "I'm not sure what that is, it looks like lime, but maintenance is responsible for cleaning this."</p> <p>On 11/18/13 at 11:55 a.m., during kitchen observation there were 2 dead roaches observed in the light fixture in the dishwashing area above the clean dish line. When the DM (dietary manager) was asked what was that in the lights indicated, "Roaches, yelp that's what that is."</p> <p>On 11/20/13 at 9:05 a.m., kitchen observation with DM indicated, pudding in bowls on a tray in the reach in refrigerator uncovered. Interview with dietary aide #1 when asked about the pudding in the reach in refrigerator indicated, " Oh it's not covered, I went on break."</p> <p>On 11/20/13 at 10:40 a.m., kitchen observation of cook #1 no handwashing observed before</p>		<p>been educated on maintenance of ice machines. The Dietary Manager / Dietary Consultant will complete a Nutrition Services "Quick Rounds" audit daily x 5 days a week for one month, then three times a week for one month, then twice weekly for one month and then weekly for 3 months. The Maintenance Director will implement a weekly cleaning schedule for the ice machines and validate completion of the cleaning schedule for three months, then twice monthly for three months. All findings will be addressed and corrected immediately and then, all findings will be reported in the monthly PI meeting and the PI committee will determine if 100% compliance has been achieved or if further monitoring is required.</p>		

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	<p>pureeing food, pot had small amount of left over turkey on bottom, Cook #1 indicated "had ground up turkey, must not have got all of it out." Observed cook #1 washing and sanitizing pot, but not allowing to dry before proceeding to add potato's for pureeing. When asked if pot still wet indicated, "still damp." When asked if food can go into wet pot, Cook #1 indicated, "technically no, well it will take 30 minutes to dry." When asked what do you do when pot remains wet, Cook #1 indicated, "I use a towel to dry. I know we're not suppose to use towels to dry." Cook #1 after completing the washing and sanitizing of pot after pureeing potato's observed handwashing for 12 seconds and then proceeded to get clean pot to puree pork.</p> <p>On 11/20/13 at 10:50 a.m., interview DM when asked if food can be placed in a wet dish indicated, "they are to let dishes dry. I'm gonna have to call and see about getting a second pot."</p> <p>On 11/20/13 at 11:10 a.m., observed DA (dietary assistant) leave and re-enter the kitchen without handwashing, put on gloves and proceed to make salads. When asked when should you handwash DA indicated, "Upon entering kitchen,</p>						

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	<p>after changing gloves, after using the washroom." When asked if [gender] did this, indicated "no" and proceeded to handwash at that time.</p> <p>On 11/21/13 at 9:20 a.m., observed the ice machine near employee breakroom and main dining room to still have white substance on both sides and back of ice machine. There was a build up of white substance on the back of the ice machine.</p> <p>Review of document received labeled "Food and Supply Storage Procedure (cont) [continue] REFRIGERATED STORAGE" with no date received from the ADM (administrator) on 11/21/13 at 9:10 a.m., indicated, ... Foods that are stored on "ladder" racks must be fully covered to prevent contamination from airborne contaminants as well as from dripping condensation. Either use a bag that covers the entire cart, or cover each tray individually."</p> <p>The DM indicated 144 Residents served from kitchen</p> <p>On 11/20/13 at 10:50 a.m., interview DM indicated, "they are to let dishes dry. I'm gonna have to call and see about getting a second pot,"</p>			

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	<p>On 11/20/ 13 at 11:10 a.m., observed DM assistant leave and re-enter without handwashing, put on gloves and proceed to make salads. When asked when should you handwash indicated, "Upon entering kitchen, after changing gloves, after using the washroom." When asked if [gender] did this, indicated "no" and proceeded to handwash at that time.</p> <p>Review of document tabled "Morrisons Policy and Procedure" no date on document received 11/21/13 at 9:10 a.m., "The 2009 FDA Food Code states that utensils must be "adequately drained" after sanitizing and before contact with food per the Code of Federal Register, 40 CFR 180.940. 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT AND UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations ...(B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry. If the utensil was properly washed, rinsed and sanitized and the excess sanitizer</p>			

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	<p>solution was drained off of the utensil before it was returned to continuous use, then there should not be an issue with the chemical contaminating the food or any growth of bacteria due to the utensil remaining wet."</p> <p>Review of the facilities current policy and procedure revised date 11/09 received from the ADM (Administrator) on 11/21/13 at 9:10 a.m., indicated, "PROCEDURES: Dish Handlers, Trayline Area Employees Air dry all food contact surfaces, including pots, dishes, flatware, and utensils before storage, or store in a self draining position..."</p> <p>Review of document labeled "Food and Supply Storage Procedures (cont) REFRIGERATED STORAGE with no date received on 11/21/13 at 9:10 a.m., from the ADM indicated, "...Food that are stored on" ladder" racks must be fully covered to prevent contamination from airborne contaminants as well as from dripping condensation. ...cover each tray individually."</p> <p>Review of documentation labeled "REFRIGERATED STORAGE LIFE OF FOODS" revised date 10/30/13 received from Nurse Consultant on</p>			

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	<p>11/21/13 at 3:00 p.m., indicated, ... Deli Meats OPENED maximum storage period 4 days (from thaw date if frozen)."</p> <p>Review of documentation labeled Hand Hygiene/Handwashing, dated 8/31/2011 received on 11/21/2013 at 9:15 a.m., from the Executive Director indicated, "Handwashing is the single most important procedure for preventing the spread of infection. If no soap and water are not available and hands are not visible soiled, an alcohol-based hands rub (ABHR) may be used for routine decontamination of hands in clinical situations...Hand hygiene is to be performed: 1. Before starting work...after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn, between tasks and procedures on the same patient when contaminated with body fluids to prevent cross-contamination of different body sites...between patient contacts...Alcohol-Based Hand Rub...Decontaminate hands before having direct contact with patient/patients..."</p> <p>3.1-21(i)(2)(3)</p>						

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000431	Resident #165's Lantus vial was discarded and a new vial removed from the EDK and dated for 11/18/2013. Resident #61's Combivent inhaler was discarded	12/25/2013			

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	<p>ensure staff documented the date multi vial medications were opened as directed by facility policy for 3 out of 9 medication carts (#1, #6, and #8) and failed to remove outdated medications for 1 of 9 medication carts (#1) reviewed.</p> <p>Findings include:</p> <p>1.) Observation of medication cart #1 on 11/18/2013 at 11:50 a.m., indicated Resident #165's Lantus vial did not have a documented open date. The container indicated the Lantus had a dispense date of 9/19/2013 and an open date of 9/24/2013 (open for 60 days).</p> <p>2.) Observation of medication cart # 3 on 11/20/2013 at 8:40 a.m., indicated Resident # 61's Combivent inhaler did not have a documented open date. The container indicated the Combivent inhaler had a dispense date of 11/11/2013.</p> <p>Observation of medication cart #3 on 11/20/2013 at 8:40 a.m., indicated Resident's # 207's NovoLog vial did not have a documented open date. The container indicated the NovoLog had a dispense date of 11/14/2013.</p> <p>3.) Observation of medication cart # 8</p>		<p>and a replacement delivered from the pharmacy and billed to the facility. Resident #61 and family were informed. Resident #207's Novolog was discarded and a new vial removed from the facility EDK and dated 11/18/2013. The DNS notified pharmacy to bill the facility for the Novolog vial and family and resident were notified. Resident #8's Latanprost was discarded and replaced by the pharmacy. Resident and family were notified and facility billed for the Latanprost. Residents #165, 61, 207, and 8 were no harmed. All residents receiving medications have the potential to be affected. An audit of all medication carts in the facility has been completed to validate all multi vial medications are dated when opened and all outdated medications are removed from the cart. All Licensed nurses have been educated on Medication Labels and Packaging. The DNS/Designee will audit all medication carts three times a week for one month, then twice a week for a month, then weekly for one month, then twice a month for three months. The DNS will report all findings monthly in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if on going monitoring is required.</p>				

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	<p>on 11/21/2013 at 12:15 p.m., indicated Resident # 146's Latanoprost bottle did not have a documented open date. The bottle indicated the Latanoprost had a dispense date of 11/12/2013.</p> <p>Interview with LPN #2 on 11/18/2013 at 11:56 a.m., indicated when asked how long insulin's storage life after opened was per policy, "28 days." When asked of the policy of insulin storage, LPN # 2 indicated, "After 28 days we have to throw the insulin away."</p> <p>Interview with QMA #1 on 11/20/2013 at 8:45 a.m., indicated when asked what is wrong with the bottle that does not have a resident's name on it, she indicated, "You won't know who it belongs to."</p> <p>On 11/21/2013 at 9:15 a.m., the Executive Director provided the Medication Labels and Packaging policy, dated 10/31/2009. Review of policy indicated, "Rationale: Medications are labeled in accordance with Center requirements, State and Federal regulations...Multi-Dose Vials and Bottles, 9. If the efficacy of the drug is affected by opening a multi-dose</p>				

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	<p>vial/bottle, initial and date the vial/bottle when opening for the first time.</p> <p>10. Discard medications by expiration date unless indicated by the pharmacy and/or manufacturer's instructions to discard sooner."</p> <p>Record review of policy Storage of Medications, dated 2/23/2011, indicated, "...19. Date insulin vials when first opened...27. Remove and dispose of according to procedures for medication disposal that are outdated...medications..."</p> <p>3.1-25(j) 3.1-25(o)</p>			

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F000441 SS=E	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000441	Resident #130, 136, 92 and 211 were not harmed. LPN #1 has	12/25/2013			

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	<p>ensure infection control practices were followed as indicated by facility policy related to hand washing during medication pass as. This deficient practice had the potential to affect 4 out of 4 residents observed. (Resident #130, Resident #136, Resident #92, Resident #211). (LPN #1)</p> <p>Findings include:</p> <p>1.) During observation on 11/20/2013 at 8:00 a.m., LPN #1 (Licensed Practical Nurse) was observed to pass medication to Resident #92. LPN #1 did not wash her hands before entering the room neither did she wash her hands before she gave medications to the resident. Resident #92 also received a nasal spray. LPN #1 did give Resident #92 nasal spray in each nostril and did not wear gloves. After administration of medications and nasal spray, LPN # 1 did not wash her hands, but she did use hand sanitizer before leaving the room.</p> <p>2.) During observation on 11/20/2013 at 8:15 a.m., LPN #1 was observed to pass medication to Resident #136. LPN #1 did not wash her hands before entering the room neither did she wash her hands before she gave</p>		<p>had written PI regarding infection control practices during medication pass. All residents on LPN #1's assignment on 11/20/2013 had the potential to be affected. An audit was completed of the residents assigned to LPN #1 for any nosocomial infections with symptoms beginning on 11/20/2013. Any findings will be reported to their MD and resident or families. All Licensed Nurses have been educated on Hygiene/Hand washing with emphasis on infection control practices during medication administration. A skills validation of Hygiene/hand washing will be completed with all nursing staff to include all nurses completing new employee orientation. A skills validation of Hygiene/hand washing will be completed with all nursing staff to include all nurses completing new employee orientation. The DNS/Designee will complete medication administration observations for implementation of infection control practices twice weekly for three months, then once weekly for three months. The observation of all nurses will include all shifts and weekends. The DNS will report all findings to the PI committee monthly and the PI committee will determine when 100% compliance is achieved or if further monitoring is required.</p>		

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	<p>medications to the resident. She proceeded to give the medications to Resident #136 and gave him an inhaler. LPN #1 did give the first dose only, because the resident gave himself the second dose. LPN #1 did not wear gloves while giving the inhaler to the resident. LPN #1 did not wash hands before leaving the room, but she did use hand sanitizer before leaving the room.</p> <p>3.) During observation on 11/20/2013 at 8:35 a.m., LPN #1 was observed to pass medication to Resident #130. LPN #1 did not wash her hands before entering the room neither did she wash her hands before medication pass. LPN # 1 did give Resident #130 eye drops in both eyes. LPN #1 did not wear gloves while administrating eye drops to Resident #130. LPN #1 did not wash her hands before leaving the room, but she did use hand sanitizer before leaving the room.</p> <p>4.) During observation on 11/20/2013 at 8:55 a.m., LPN #1 was observed to pass medication to Resident #211. LPN #1 did not wash her hands before entering the room neither did she wash her hands before medication pass. After medication pass, LPN #1 did not wash her hands</p>						

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	<p>before leaving the room, but she did use hand sanitizer before leaving the room.</p> <p>LPN #1 did not wash her hands in any of the resident's rooms. Each resident's room had water with sink and soap. LPN #1 only used hand sanitizer.</p> <p>Interview with Unit Manager of Sycamore Hall, on 11/25/2013 at 9:00 a.m., indicated when asked what the policy and procedure was on hand washing while passing medications, "Well, you have to wash your hands after each resident. I want my nurses to wash their hands before resident care, apply gloves and do medications, take gloves off again and then wash hands again."</p> <p>On 11/21/2013 at 9:15 a.m., the Executive Director provided Hand Hygiene/Handwashing, dated 8/31/2011, indicated, "Handwashing is the single most important procedure for preventing the spread of infection. If no soap and water are not available and hands are not visible soiled, an alcohol-based hands rub (ABHR) may be used for routine decontamination of hands in clinical situations...Hand hygiene is to be performed:</p>			

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	<p>1. Before starting work...after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn, between tasks and procedures on the same patient when contaminated with body fluids to prevent cross-contamination of different body sites...between patient contacts...Alcohol-Based Hand Rub...Decontaminate hands before having direct contact with patient/patients..."</p> <p>3.1-18(l)</p>			