

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/25/2012
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NAME OF PROVIDER OR SUPPLIER  HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the investigation of complaint IN00118436.</p> <p>Complaint IN00118436 substantiated, federal/state deficiencies related to the allegations are cited at F157 and F309.</p> <p>Survey dates: October 22, 23, 24 and 25, 2012</p> <p>Facility number: 002703 Provider number: 155680 AIM number: 200309250</p> <p>Survey team: Rita Mullen, RN, TC Janet Stanton, RN (October 22, 23 &amp; 25, 2012) Michelle Carter, RN Heather Lay, RN (October 23, 24 &amp; 25, 2012)</p> <p>Census bed type: SNF/NF: 35 SNF: 18 Residential: 32 Total: 85</p> <p>Census payor type:</p>	F0000	<p><b>F 0000</b></p> <p><b>Submission of this plan of correction does not constitute an admission by Homewood Health Campus of any wrong-doing or failure to comply with the Federal or State Regulations.</b></p> <p><b>Homewood Heath Campussubmits this plan of courcection as its letter of credible allegation and is <u>requesting a desk review</u>. All corrective actions will be completed by November 24, 2012.</b></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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	<p>Medicare: 12 Medicaid: 21 Other: 52 Total: 85</p> <p>Sample: 14 Supplemental sample: 6 Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/31/12 Cathy Emswiler RN</p>				

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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation and interview, the facility failed to ensure information regarding Medicare, Medicaid, and contacting advocacy agencies was posted in a location and at a height readily accessible to the residents. This deficient practice had the potential to affect 53 of 53 residents who resided at the facility. [Resident #4]</p> <p>Findings include:</p> <p>On 10/24/12 at 9:30 A.M., environmental tour was initiated with the Director of Plant Operations.</p> <p>At that time, in the main hallway, information regarding Medicare, Medicaid, and how to contact advocacy agencies was observed in individual 8 x 10 frames. The information was hard to</p>	F0156	<p><b>F 156 All information located in main hallway regarding Medicare, Medicaid, and how to contact advocacy agencies which are in 8x10 frames were immediately moved to a lower position ( 60 inches from the floor) to accommodate all the residents to be affected by the alleged deficient practice. An audit tool was created to monitor all signage in the main hallway remain at 60 inches from the floor. This audit tool will be completed by the Executive Director/designee weekly for six months to ensure that the deficient practice does not recur. All results will be reported each month to QA committee for six months for review and changes to ensure the deficient practice will not recur. Date of Compliance: 11.09.12</b></p>	11/09/2012

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	<p>read in the standing position. The information was too high to read.</p> <p>On 10/24/12 at 10:30 A.M., the group meeting was initiated.</p> <p>At that time, in an interview, Resident #4 indicated he was aware of where the information regarding Medicare, Medicaid, and the numbers for advocacy agencies; however, since he was in a wheelchair, the could not read the information in the hallway.</p> <p>On 10/25/12 at 9:30 A.M., in an interview, the Executive Director indicated the information had been moved to a lower position to accommodate the residents.</p> <p>3.1-3(b)(1)</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of a resident's level of pain that was not relieved with non-pharmacological interventions or</p>	F0157	<b>F157 Resident B was discharged on 9/17/2012 All residents who require pain management have potential to be affected by alleged deficient practice. Medical Records</b>	11/15/2012	

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	<p>routine pain medication. Resulting in the resident requesting additional PRN (as needed) pain medication forty two times in thirteen days. This impacted 1 of 7 residents reviewed for pain control in a sample of 14. (Resident B)</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 10/23/12 at 9:00 A.M.</p> <p>Diagnoses included, but were not limited to, osteoporosis, left humeral fracture, intractable pain secondary to fracture, chronic back pain and high blood pressure.</p> <p>A Quarterly Minimum Data Set assessment, dated 7/17/12, indicated a Brief Interview for Mental Status score of 15 (cognitively intact and able to make decisions).</p> <p>Admission orders for Resident B, dated 6/4/12, included, but were not limited to:</p> <p>Dilaudid (a narcotic pain medication) 4 mg (milligrams) by mouth every 4 hours PRN for break through pain.</p> <p>Gabapentin (for chronic pain) 600 mg three times a day by mouth.</p>		<p><b>Coordinator/Designee will audit Medication Administration Records of 5 random residents with PRN pain medication for increased usage of prn pain medications and notification of physician of increased usage 2 x week x 4 weeks, then 1 x week x 4 weeks, then monthly thereafter x 6 months to ensure that deficient practice does not recur. Twenty-four hour nursing reports and pain circumstances sheets will be reviewed daily in Clinical Care Meeting by Nursing Leadership Team for resident complaints of pain, interventions into complaints of pain, effectiveness of interventions, notification of physician as needed for increased usage by a resident of prn pain medications and/or complaints of pain being unresolved with administration of prn pain medication. Unit Manager will review pain circumstance sheets x 72 hours to ensure an increase/decrease in pain medication resulted in effective pain control. Assisted Director Health Services/Designee will inservice all licensed nursing staff on pain management on 11.14.2012 All results will be reported each month to QA committee for monthly for 6 months for review and changes</b></p>		

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	<p>Exalgo (a slow release form of Dilaudid) 12 mg by mouth daily.</p> <p>A Care Plan for pain, dated 6/15/12, indicated Resident B had chronic pain, complained of pain and a fractured left humerus. Interventions included, but were not limited to, observe and report to nurse: signs of pain, worsening of pain, comfort measures, monitor effectiveness...of routine pain medication &amp; PRN medication, and notify the resident's physician if they do not demonstrate relief or reduction of pain.</p> <p>A PRN Medication Tracking form, dated for the month of June 2012, indicated from 6/4/12 to 6/18/12, Resident B reported having back and shoulder pain at a 7 level (severe 6 - 8) 24 times, at an 8 level 19 times, at a 9 level (9 - 10 excruciating) 6 times and at a 10 level 2 times. The resident was administered the PRN pain medication but the physician was not notified regarding the number of times the resident complained of pain not relived by the routine pain medication.</p> <p>A Physician's order, dated 6/18/12, increased the PRN Dilaudid from 4 mg every 4 hours to 8 mg every 4</p>		<p><b>to ensure the deficient practice will not recur. Date of Compliance: 11.15.2012</b></p>		

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	<p>hours and added Dilaudid 4 mg twice a day. The resident also continued to receive the Exalgo daily and the Gabapentin 600 mg three times a day.</p> <p>A Physician's order, dated 6/25/12, discontinued the Exalgo 12 mg daily.</p> <p>A Physician's order, dated 6/27/12,, discontinued the Dilaudid 8 mg every 4 hours PRN and an order for a pain consult physician.</p> <p>A review of the Medication Administration Record, for the month of June 2012, indicated Resident B requested the Dilaudid 8 mg PRN two times on 6/19/12, one time on 6/20/12, two times on 6/21/12 and none on June 22nd, 23rd, 24th, 25th, or 26th. There were two requests on June 27th.</p> <p>During an interview with Regional Nurse consultant #8, on 10/25/12 at 3:20 P.M., she indicated there was no information regarding the physician being notified of Resident B's repeated requests for PRN pain medication from 6/5/12 until 6/18/12, when the Dilaudid was increased to control pain.</p> <p>This Federal tag relates to Complaint IN00118436.</p>			

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	3.1-5(a)(3)			

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F0167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to post a notice that was easily accessible to residents of recent survey availability and the facility failed to clearly identify the survey binder. The deficient practice had the potential to affect 53 of 53 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 10/24/12 at 9:30 A.M., environmental tour was initiated with the Director of Plant Operations.</p> <p>At that time, a binder was observed on a coffee table in the front lobby with the title, "Homewood Health Campus."</p> <p>The binder included the facility's survey results since the last annual survey. However, there no observation was made of a sign in the lobby or a label on the</p>	F0167	<p><b>F 167</b></p> <p>All information located in main hallway regarding our survey binder location which is in 8x10 frames was immediately moved to a lower position to accommodate all the residents to be affected by the alleged deficient practice on 10.24.12. The survey binder was correctly identified as our survey binder on 10.24.12 which has the results available for examination of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>An audit tool was created to monitor survey binder in the main lobby. The audit tool will be completed by the Executive Director/designee weekly for six months.</p> <p>All results will be reported each month to QA committee for six months for review and changes to ensure the deficient practice will</p>	11/09/2012	

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	<p>binder that indicated what was in the binder. The sign was too high to read.</p> <p>The notice regarding where the survey results were located was in the main hallway at a height that was difficult to read for a person standing.</p> <p>On 10/25/12 at 9:30 A.M., in an interview, the Executive Director indicated she lowered the sign at a level that was more accessible and readable to the residents.</p> <p>3.1-3(b)(1)</p>		<p><b>not occur.</b></p> <p><b>Date of Compliance: 11.09.12</b></p>		

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F0223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were free from abuse by facility staff. This deficient practice affected 2 of 2 residents reviewed for abuse in a supplemental sample of 6 residents reviewed. [Residents #63 and #64]</p> <p>Findings include:</p> <p>1. On 10/24/12 at 9:30 A.M., the Executive Director provided an abuse investigation for Residents #63 and #64.</p> <p>The facility abuse investigation included, but was not limited to the following:</p> <p>An "Indiana State Department of Health Incident Report Form" included, but was not limited to, "Incident Date: 2/28/12 at 1730... Resident Name: [Resident #63 and Resident #64]... Staff Involved: [CNA #1]... Brief Description of Incident: [CNA #1] was observed by [CNA #2] being rough while providing care [to]</p>	F0223	<p><b>F 223</b> Homewood Health Campus, under Trilog Health Services, has developed and implemented processes which strive to ensure the prevention of suspected or alleged resident abuse and neglect. Homewood Health Campus has implemented processes in an effort to provide a comfortable and safe environment. The Executive Director and Director of Health Service are responsible for the implementation and ongoing monitoring of abuse standards and procedures to ensure our residents will be free from abuse by facility staff. The Director of Nursing/designee will review all Incident and Accident Reports routinely to monitor for indicators leading to suspected abuse or neglect to ensure the deficient practice will not recur. Social Services will randomly interview five (5) residents weekly times four (4) weeks , every two weeks time four weeks and monthly times six months to</p>	11/09/2012			

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	<p>[Resident #63] and while giving a shower [to] [Resident #64]... Type of Injuries: [Resident #64] was noted to have a deep purple bruise to left upper forearm outer aspect... measuring 4.5 centimeters by 2.5 centimeters... Immediate Action Taken: Both CNAs were placed on immediate suspension for 3 days for further investigation... [CNA #2] for not reporting observed abuse immediately... Both residents has [sic] full body skin assessments and were check [sic] for injuries... Families and MD's were notified... Preventive Measures Taken: All nursing staff were interviewed... four alert and oriented residents were interviewed... [Resident #63] and [Resident #64] were interviewed... No one reported observing or receiving inappropriate care by [CNA #1]... All staff immediately inserviced on abuse training... [CNA #1] was terminated due to observation by [CNA #2] and the bruise noted on [Resident #64]</p> <p>A written statement from [CNA #2], dated 2/28/12, no time, included, but was not limited to, "I have witness [sic] abusive behavior from [CNA #1] towards several different residents [Resident #63] and [Resident #64] on a couple of different occasions... Feb 24 [2/24/12] I [CNA #2] observed [CNA #1] bending [Resident #63's] arm back the wrong way</p>		<p><b>ensure residents are free from all types of abuse.</b> <b>Training on Abuse and Neglect Procedural for all new employees through orientation and with yearly ongoing training programs will be monitored by the Assistance Director of Nursing/designee to ensure the deficient practice will not recur.</b> <b>All results will be reported each month to QA committee for six months for review and changes to ensure the deficient practice will not recur.</b> <b>Date of Compliance: 11.09.12</b></p>				

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	<p>and just being excessively rough with her and with [Resident #64] today in the shower excessively rough yanking her through the shower door hitting her arm washing her roughly..."</p> <p>A written statement from Director of Social Services, dated 3/2/12, no time, indicated Residents #4, #19, #65, and #39 were interviewed and denied any concerns regarding their care or safety.</p> <p>2. On 10/24/12 at 2:45 P.M., Resident #63's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, depression, and anxiety.</p> <p>Resident #63 was discharged from the facility on 8/6/12.</p> <p>A "Brief Interview Mental Status" dated 3/19/12, indicated a score of 6 [severe cognitive impairment].</p> <p>A "Social Service Progress Notes" dated 3/2/12, no time, included, but was not limited to, "Attempted an interview with resident to ask about concerns with safety and or care... when asked do you feel safe, resident nodded yes... when asked do you feel unsafe or have people hurt you, resident nodded yes... it is unclear whether resident feels safe in her environment due to her inability to</p>			

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	<p>communicate effectively..."</p> <p>3. On 10/24/12 at 2:55 P.M., Resident #64's record was reviewed. Diagnoses included, but were not limited to, malaise, fatigue, and biliary cirrhosis.</p> <p>Resident #64 no longer resided at the facility.</p> <p>A "Brief Interview Mental Status" dated 3/19/12, indicated a score of 3 [sever cognitive impairment].</p> <p>A "Social Service Progress Notes" dated 3/2/12, no time, included, but was not limited to, "Resident interviewed on this date... asked if there are or were any concerns related to safety and care... stated no... when asked has any staff hurt you, resident responded no..."</p> <p>On 10/24/12 at 1:00 P.M., in an interview, the Executive Director indicated CNA #1 was terminated related to the abuse allegation and CNA #2 was suspended related to not notifying her immediately regarding the 2 incidents of physical abuse. She indicated both incidents occurred on 2/24/12 and CNA #2 did not report the observed abuse until 2/28/12 [no time given].</p> <p>3.1-27(a)(1)</p>				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the</p>	F0225	F 225	11/09/2012			

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	<p>facility failed to ensure nursing staff reported an allegation of alleged abuse immediately to the facility Administrator. This deficient practice affected 2 of 2 residents reviewed for abuse in a supplemental sample of 6 residents reviewed. [Residents #63 and #64]</p> <p>Findings include:</p> <p>1. On 10/24/12 at 9:30 A.M., the Executive Director provided an abuse investigation for Residents #63 and #64.</p> <p>The facility abuse investigation included, but was not limited to the following:</p> <p>An "Indiana State Department of Health Incident Report Form" included, but was not limited to, "Incident Date: 2/28/12 at 1730... Resident Name: [Resident #63 and Resident #64]... Staff Involved: [CNA #1]... Brief Description of Incident: [CNA #1] was observed by [CNA #2] being rough while providing care [to] [Resident #63] and while giving a shower [to] [Resident #64]... Type of Injuries: [Resident #64] was noted to have a deep purple bruise to left upper forearm outer aspect... measuring 4.5 centimeters by 2.5 centimeters... Immediate Action Taken: Both CNAs were placed on immediate suspension for 3 days for further investigation... [CNA #2] for not</p>		<p><b>Homewood Health Campus, under Trilogy Health Services, has developed and implemented processes which strive to ensure the prevention of suspected or alleged resident abuse and neglect. Homewood has implemented processes in an effort to provide a comfortable and safe environment. The Executive Director and Director of Health Service are responsible for the implementation and ongoing monitoring of abuse standards and procedures to accommodate all the residents to be affected by the alleged deficient practice.</b></p> <p><b>Abuse and Neglect Procedural Training is provided for all new employees through orientation and with yearly ongoing training programs which includes immediately notifying the Executive Director or their designee in their absence of any abuse, neglect and misappropriation of resident property to ensure the deficient practice will not recur.</b></p> <p><b>The Director of Nursing/designee will review all Incident and Accident Reports routinely to monitor for indicators leading to suspected abuse or neglect to ensure the deficient practice will not recur. All results will be reported each month to QA committee for six months for review and changes to ensure the deficient practice will not recur.</b></p>		

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	<p>reporting observed abuse immediately... Both residents has [sic] full body skin assessments and were check [sic] for injuries... Families and MD's were notified... Preventive Measures Taken: All nursing staff were interviewed... four alert and oriented residents were interviewed... [Resident #63] and [Resident #64] were interviewed... No one reported observing or receiving inappropriate care by [CNA #1]... All staff immediately inserviced on abuse training... [CNA #1] was terminated due to observation by [CNA #2] and the bruise noted on [Resident #64]</p> <p>A written statement from [CNA #2], dated 2/28/12, no time, included, but was not limited to, "I have witness [sic] abusive behavior from [CNA #1] towards several different residents [Resident #63] and [Resident #64] on a couple of different occasions... Feb 24 [2/24/12] I [CNA #2] observed [CNA #1] bending [Resident #63's] arm back the wrong way and just being excessively rough with her and with [Resident #64] today in the shower excessively rough yanking her through the shower door hitting her arm washing her roughly..."</p> <p>A written statement from Director of Social Services, dated 3/2/12, no time, indicated Residents #4, #19, #65, and #39</p>		Date of Compliance: 11.09.12				

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	<p>were interviewed and denied any concerns regarding their care or safety.</p> <p>2. On 10/24/12 at 2:45 P.M., Resident #63's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, depression, and anxiety.</p> <p>Resident #63 was discharged from the facility on 8/6/12.</p> <p>A "Brief Interview Mental Status" dated 3/19/12, indicated a score of 6 [severe cognitive impairment].</p> <p>A "Social Service Progress Notes" dated 3/2/12, no time, included, but was not limited to, "Attempted an interview with resident to ask about concerns with safety and or care... when asked do you feel safe, resident nodded yes... when asked do you feel unsafe or have people hurt you, resident nodded yes... it is unclear whether resident feels safe in her environment due to her inability to communicate effectively..."</p> <p>3. On 10/24/12 at 2:55 P.M., Resident #64's record was reviewed. Diagnoses included, but were not limited to, malaise, fatigue, and biliary cirrhosis.</p> <p>Resident #64 no longer resided at the facility.</p>						

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	<p>A "Brief Interview Mental Status" dated 3/19/12, indicated a score of 3 [sever cognitive impairment].</p> <p>A "Social Service Progress Notes" dated 3/2/12, no time, included, but was not limited to, "Resident interviewed on this date... asked if there are or were any concerns related to safety and care... stated no... when asked has any staff hurt you, resident responded no..."</p> <p>On 10/24/12 at 1:00 P.M., in an interview, the Executive Director indicated CNA #1 was terminated related to the abuse allegation and CNA #2 was suspended related to not notifying her immediately regarding the 2 incidents of physical abuse. She indicated both incidents occurred on 2/24/12 and CNA #2 did not report the observed abuse until 2/28/12 [no time given].</p> <p>3.1-28(c)(2)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting alleged abuse immediately to the Administrator and failed to properly screen the alleged violator [CNA #1] prior to employment. The deficient practice affected 2 of 2 residents reviewed for abuse allegations in a supplemental sample of 6 residents reviewed. [Residents #63 and #64]</p> <p>Findings include:</p> <p>1. On 10/24/12 at 9:30 A.M., the Executive Director provided an abuse investigation for Residents #63 and #64.</p> <p>The facility abuse investigation included, but was not limited to the following:</p> <p>An "Indiana State Department of Health Incident Report Form" included, but was not limited to, "Incident Date: 2/28/12 at 1730... Resident Name: [Resident #63 and Resident #64]... Staff Involved: [CNA #1]... Brief Description of Incident:</p>	F0226	<p>F 226</p> <p>Homewood Health Campus, under Trilogy Health Services, has developed and implemented processes which strive to ensure the prevention of suspected or alleged resident abuse and neglect. Homewood has implemented processes in an effort to provide a comfortable and safe environment. The Executive Director and Director of Health Service are responsible for the implementation and ongoing monitoring of abuse standards and procedures to accommodate all the resident to be affected by the alleged deficient practice.</p> <p>Homewood Health Campus will not knowingly employ individuals who have been found guilty of abuse, neglect, or misappropriation of resident property. Implementation and monitoring consists of screening all potential employees for a history of abuse, neglect or mistreatment of patients during the hiring process to accommodate all the resident to be affected by the alleged deficient practice.</p> <p>An audit tool was created to monitor each potential employee</p>	11/09/2012	

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	<p>[CNA #1] was observed by [CNA #2] being rough while providing care [to] [Resident #63] and while giving a shower [to] [Resident #64]... Type of Injuries: [Resident #64] was noted to have a deep purple bruise to left upper forearm outer aspect... measuring 4.5 centimeters by 2.5 centimeters... Immediate Action Taken: Both CNAs were placed on immediate suspension for 3 days for further investigation... [CNA #2] for not reporting observed abuse immediately... Both residents has [sic] full body skin assessments and were check [sic] for injuries... Families and MD's were notified... Preventive Measures Taken: All nursing staff were interviewed... four alert and oriented residents were interviewed... [Resident #63] and [Resident #64] were interviewed... No one reported observing or receiving inappropriate care by [CNA #1]... All staff immediately inserviced on abuse training... [CNA #1] was terminated due to observation by [CNA #2] and the bruise noted on [Resident #64]</p> <p>A written statement from [CNA #2], dated 2/28/12, no time, included, but was not limited to, "I have witness [sic] abusive behavior from [CNA #1] towards several different residents [Resident #63] and [Resident #64] on a couple of different occasions... Feb 24 [2/24/12] I</p>		<p><b>reference checks from previous/current employers. All employees that hire potential employee will use this audit tool to monitor each potential employee reference checks from previous/current employers. The audit tool will be reviewed by the Executive Director/designee before each potential employee is hired to ensure the deficient practice does not recur.</b></p> <p><b>All results will be reported each month to the QA committee for 6 months for review and changes to ensure the deficient practice will not recur.</b></p> <p><b>Date of Compliance: 11.09.12</b></p>		

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	<p>[CNA #2] observed [CNA #1] bending [Resident #63's] arm back the wrong way and just being excessively rough with her and with [Resident #64] today in the shower excessively rough yanking her through the shower door hitting her arm washing her roughly..."</p> <p>A written statement from Director of Social Services, dated 3/2/12, no time, indicated Residents #4, #19, #65, and #39 were interviewed and denied any concerns regarding their care or safety.</p> <p>2. On 10/25/12 at 10:00 A.M., the Executive Director provided CNA #1's employee file. The employee file only contained 1 reference check.</p> <p>On 10/25/12 at 10:30 A.M., in an interview, the Executive Director indicated it is hard to get references back at times and did not provide any other references for CNA #1.</p> <p>The facility provided their abuse prohibition policies and procedures upon entrance to the facility on 10/22/12.</p> <p>The policies and procedures, included, but were not limited to, "Purpose: Trilogy Health Services, LLC has developed and implemented processes, which strive to ensure the prevention and reporting of</p>				

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	<p>suspected or alleged resident abuse and neglect... Screening: Screen all potential employees for a history of abuse, neglect, or mistreatment of patients during the hiring process... Reference checks form previous/current employers... Identification: Any person with knowledge or suspicion of suspected violations shall report immediately.... immediately notify the Executive Director or their designee in their absence..."</p> <p>3.1-28(a)</p>			

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F0279 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 ensure that a coordinated Care Plan was developed in conjunction between the facility and a Hospice agency, which clearly outlined the specific responsibilities and services to be provided by each; for 2 of 3 residents reviewed who were receiving Hospice services [Residents #6 and #43]; and failed to develop individualized behavior interventions for 1 of 5 residents receiving psychotropic medications [Resident #24]; in a sample of 14 residents reviewed.</p>	F0279	<p><b>F279</b> Resident # 24 PRN Medication Tracking form reviewed per SSD and updated to match care plan individualized interventions. All residents receiving PRN Psychotropic medications could be affected by this alleged deficient practice. SSD will review all PRN Tracking sheets of residents who receive PRN Psychotropic Medications to ensure PRN Tracking Sheets interventions match each residents individualized behavior care plan interventions to ensure that deficient practice does not recur.</p>	11/14/2012	

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	<p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 10/22/12 at 9:50 A.M., L.P.N. #9 indicated Resident #24 had a diagnosis of bipolar disease which was controlled by psychotropic medications.</p> <p>The clinical record for Resident #24 was reviewed on 10/22/12 at 1:05 P.M. The resident was originally admitted to the facility on 8/3/12 with diagnoses that included, but were not limited to, mixed receptive/expressive language, chronic obstructive pulmonary disease, and history of bipolar disease.</p> <p>The October, 2012 physician order recap [recapitulation] sheet listed an order, dated 8/18/12, for Lorazepam [an anti-anxiety medication] 0.5 mg. [milligrams] one by mouth every 8 hours PRN [as needed].</p> <p>An August, 2012 "PRN Medication Tracking" form indicated Resident #24 received 10 doses of Lorazepam between 8/17 and 8/28/12 for "Anxiety (pacing, hand wringing, rocking, expressions of anxiety, etc.)."</p> <p>The key list of "Interventions tried</p>		<p>SSD will be responsible to fill out interventions on PRN tracking sheets each month for those residents on PRN Psychotropic to ensure that PRN tracking sheet and care plan interventions are individualized and match to ensure that deficient practice does not recur.</p> <p>SSD will report results each month of audits to QA Committee monthly x 6 months for review and changes to ensure the deficient practice will not recur.</p> <p>Resident # 43 and Resident #11 Hospice care plans were reviewed and immediately updated corrected to reflect hospice care. per MDS Coordinator on 10/24/2012.</p> <p>Resident #11 has since been discharged.</p> <p>All Residents receiving Hospice Care have the potential to be affected by alleged deficient practice MDS Coordinator reviewed and individualized all care plans of Hospice residents.</p> <p>Hospice Providers are to attend all care plan meetings related to Hospice residents. During care plan meetings, MDS, SSD, Hospice Provider and Unit Manager will review and coordinate all Hospice and facility Hospice care plans to ensure that all care plans are individualized, complete and match to ensure that deficient practice does not recur.</p> <p>MDS Coordinator will report any</p>		

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	<p>before medications" listed: "1. Walking; 2. Bed rest; 3. Reading; 4. Music [kind not specified]; 5. Diversion [kind not specified]; 6. Toileting; 7. Food/drink; 8. Back rub/massage; 9. Call family member; 10. SS [Social Service] intervene; 11. Place close to nursing station or in common area; 12. Take to room; 13. 1:1 [One to One] time [kind not specified]; 14. Reassurance; 15. Position for comfort; 16. Hot/cold compress." Numbers 17, 18, 19, and 20 had lines for "Other" specific interventions, unique to the resident, to be written in.</p> <p>The August interventions tried each time prior to the administration of the Lorazepam for Resident #24 were documented as "5., 13., 14., and 15." Other interventions tried, specific to the resident to help relieve her anxiety, were not listed.</p> <p>The September, 2012 "PRN Medication Tracking" form indicated the resident received 10 doses of Lorazepam between 9/3 ant 9/26/12. The interventions tried were "13., 14., 15." with occasional "2., 6., 7., 9." Other interventions tried, specific to the resident to help relieve her anxiety, were not listed.</p>		<p><b>discrepancies in Hospice care plans to QA Committee monthly x 6 months to ensure the deficient practice will not recur.</b> <b>Date of Compliance: 11.14.12</b></p>				

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	<p>In an interview on 10/25/12 at 10:00 A.M., the Assistant Director of Nursing indicated the resident's use of the Lorazepam had been decreasing as she became more accustomed to living in the facility. She indicated the facility had not formulated any plans for using interventions that were more specific to the resident.</p> <p>2. On 10/23/12 at 12:45 A.M., Resident #43's record was reviewed. Diagnoses included, but were not limited to, heart failure, hypertension, and Alzheimer's disease.</p> <p>Resident #43 was admitted to hospice on 7/24/12.</p> <p>A hospice care plan, included, but was not limited to, "Problems [8/14/12]: Hospice... Resident has a terminal condition related to Alzheimer's and is receiving hospice services... Goals: Resident will be free from unrelenting pain and discomfort... Interventions: Observe for signs and symptoms of pain or discomfort... Maintain good communication with hospice... Hospice RN support [left blank] days per week... Hospice aid [sic] to visit [left blank] days per week and provide services [no services listed]... Hospice to provide pain management support [no pain regimen listed]... Hospice to provide psychological support [left blank] days per week..."</p> <p>There was no documentation of an individualized hospice care plan for Resident #11.</p> <p>On 10/24/12 at 11:00 A.M., in an interview, Regional Nurse Consultant #7 indicated the facility did not have a coordinated hospice care</p>			

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	<p>plan for Resident #43. She further indicated the facility used a generic care plan for all hospice residents and did not have an individualized care plan for any of the hospice residents.</p> <p>3. On 10/24/12 at 2:00 P.M., Resident #6's record was reviewed. Diagnoses included, but were not limited to, congestive heart failure and coronary artery disease.</p> <p>Resident #6 was admitted to hospice on 9/24/12.</p> <p>A hospice care plan, included, but was not limited to, "Problem [1/16/12]: Hospice:... Resident is in terminal condition related to [left blank] and is receiving hospice service... Goals: Resident will be free from unrelenting pain and discomfort... Interventions: Hospice provides RN support as needed days per week 1 time per week for 12 weeks... Hospice aid [sic] to visit as needed days per week and provide services 3 times per week for 12 weeks... Hospice to provide pain management support [no pain regimen listed]... Hospice to provide psychological support as needed days per week..."</p> <p>There was no documentation of an individualized hospice care plan for Resident #6.</p> <p>On 10/24/12 at 11:00 A.M., in an interview, Regional Nurse Consultant #7 indicated the facility did not have a coordinated hospice care plan for Resident #6.</p> <p>3.1-35(b)(1)</p>			

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F0282 SS=D	<p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b> 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 a physician's order and Care Plan intervention was followed to check pacemaker heart rate parameters daily, for 1 of 1 residents who had such orders; in a sample of 14 residents reviewed. [Resident #2]</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 10/22/12 at 10:00 A.M., L.P.N. #9 indicated Resident #2 was being seen by a Wound Clinic for a shear open area of his right shoulder blade, had been losing weight steadily, and required a mechanical lift for transfers.</p> <p>The clinical record for Resident #2 was reviewed on 10/23/12 at 10:00 A.M. Diagnoses included, but were not limited to, Parkinson's disease, dysphagia with weight loss, aphasia, dementia, history of acute renal failure, and history of a pacemaker placement.</p>	F0282	<p><b>F282</b> Resident # 2 was discharged from the facility on 10.24.12.. All residents who have pacemakers have the potential to be affected from alleged deficient practice. All residents with pacemakers shall be scheduled and monitored by routine pacemaker checks per physician orders to accommodate all the residents to be affected by the alleged deficient practice. Medical Records Coordinator/designee will audit charts of residents and new admission with pacemakers 1x monthly x 6 months to ensure physician orders are followed as ordered to ensure the deficient practice does not recur. Medical Records Coordinator/designee will report each month to the QA committee for 6 months to review and changes to ensure the deficient practice will not recur. Date of Compliance: 11.14.12</p>	11/14/2012	

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	<p>The October, 2012 physician order recap [recapitulation] sheet listed an order, dated 4/25/12, for "Pacemaker parameters=check heart rate every day and notify M.D. for heart rate less than 50 or greater than 110."</p> <p>A Care Plan entry, with no start date but updated 10/22/12, addressed a "problem" of "Risk for decreased cardiac output related to ... has pacemaker...." One of the interventions listed was "Pacemaker check per orders.</p> <p>The August, 2012 M.A.R./T.A.R. [Medication/Treatment Administration Record] listed the order for the pacemaker heart rate check. There were no entries for 8/2, 3, 4, 6, 7, 11, 12, 17, and 21, 2012.</p> <p>The September, 2012 M.A.R./T.A.R. had no entries for the entire month.</p> <p>The October, 2012 M.A.R./T.A.R. had no entries for 10/1 to 10/20/12.</p> <p>In an interview during the daily conference on 10/23/12 at 3:00 P.M., the Assistant Director of Nursing indicated the documentation of the heart rate would not be recorded in the A.D.L. Care-Tracker system. She indicated she would need to check</p>						

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	<p>and see if the heart rates were record on some other record/form.</p> <p>In an interview on 10/25/12 at 9:00 A.M., the Executive Director indicated they were unable to locate any other documentation demonstrating the heart rate was checked daily as ordered. She indicated it had not been done.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to control a resident's pain level by not contacting the physician to request a change in treatment or altering non-pharmacological interventions that were not effective for relieving pain. This impacted 1 of 7 residents reviewed for pain control in a sample of 14. (Resident B)</p> <p>Findings include.</p> <p>The clinical record of Resident B was reviewed on 10/23/12 at 9:00 A.M.</p> <p>Diagnoses included, but were not limited to, osteoporosis, left humeral fracture, intractable pain secondary to fracture, chronic back pain and high blood pressure.</p> <p>A Quarterly Minimum Data Set assessment, dated 7/17/12, indicated a Brief Interview for Mental Status score of 15 (cognitively intact and able to make decisions).</p>	F0309	<p><b>F 309</b>  Resident B was discharged on 9/17/2012  All residents who require pain management have potential to be affected by alleged deficient practice.  Medical Records  Coordinator/Designee will audit Medication Administration Records of 5 random residents with PRN pain medication for increased usage of prn pain medications and notification of physician of increased usage 2x week x 4 weeks, then 1xweek x 4weeks, then monthly thereafter x 6 months to ensure that deficient practice does not recur.  Twenty-four hour nursing reports and pain circumstances sheets will be reviewed daily in Clinical Care Meeting by Nursing Leadership Team for resident complaints of pain, interventions into complaints of pain, effectiveness of interventions, notification of physician as needed for increased usage by a resident of prn pain medications and/or complaints of</p>	11/15/2012	

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	<p>Admission orders for Resident B, dated 6/4/12, included, but were not limited to:</p> <p>Dilaudid (a narcotic pain medication) 4 mg (milligrams) by mouth every 4 hours PRN for break through pain.</p> <p>Gabapentin (for chronic pain) 600 mg three times a day by mouth.</p> <p>Exalgo (a slow release form of Dilaudid) 12 mg by mouth daily.</p> <p>A Pain Circumstance, Assessment, Data Collection and Intervention from, dated 6/4/12, indicated Resident B had a recent fracture &amp; history of kyphosis. Pain was acute and chronic and described as severe. Resident B was receiving routine pain medication and pain medication PRN. The Resident's symptoms related to pain was facial expression. The effectiveness of pain medication was to be evaluated and the physician notified if ineffective.</p> <p>A Care Plan for pain, dated 6/15/12, indicated Resident B had chronic pain, complained of pain and a fractured left humerus. Interventions included, but were not limited to, observe and report to nurse: signs of</p>		<p><b>pain being unresolved with administration of prn pain medication. Unit Manager will review pain circumstance sheets x 72 hours to ensure an increase/decrease in pain medication resulted in effective pain control.</b></p> <p><b>ADHS/Designee will inservice all licensed nursing staff on pain management on 11.14.2012</b></p> <p><b>All results will be reported each month to QA committee for monthly for 6 months for review and changes to ensure the deficient practice will not recur.</b></p> <p><b>Date of Compliance: 11.15.2012</b></p>		

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	<p>pain, worsening of pain, comfort measures, monitor effectiveness...of routine pain medication &amp; PRN medication, and notify the resident's physician if they do not demonstrate relief or reduction of pain.</p> <p>A PRN Medication Tracking form, dated for the month of June 2012, indicated from 6/4/12 to 6/18/12, Resident B reported having back and shoulder pain at a 7 level (severe 6 - 8) 24 times, at an 8 level 19 times, at a 9 level (9 - 10 excruciating) 6 times and at a 10 level 2 times.</p> <p>Non-pharmacological interventions of 1:1 time, reassurance and position for comfort were not effective. No other non-pharmacological interventions were used.</p> <p>A Physician's order, dated 6/18/12, increased the PRN Dilaudid from 4 mg every 4 hours to 8 mg every 4 hours and added Dilaudid 4 mg twice a day. The resident also continued to receive the Exalgo daily and the Gabapentin 600 mg three times a day.</p> <p>A Physician's order, dated 6/25/12, discontinued the Exalgo 12 mg daily.</p> <p>A Physician's order, dated 6/27/12,, discontinued the Dilaudid 8 mg every 4 hours PRN and an order for a pain</p>						

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	<p>consult physician.</p> <p>A review of the Medication Administration Record, for the month of June 2012, indicated Resident B requested the Dilaudid 8 mg PRN two times on 6/19/12, one time on 6/20/12, two times on 6/21/12 and none on June 22nd, 23rd, 24th, 25th, or 26th. There were two requests on June 27th.</p> <p>During an interview with Regional Nurse consultant #8, on 10/25/12 at 3:20 P.M., she indicated there was no information regarding the physician being notified of Resident B's repeated requests for PRN pain medication from 6/5/12 until 6/18/12, when the Dilaudid was increased to control pain.</p> <p>This Federal tag relates to Complaint IN00118436.</p> <p>3.1-37(a)</p>				

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F0323 SS=E	<p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b> 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 observation, interview, and record review, the failed to secure chemicals on 1 unit of the facility. This deficient practice had the potential to affect 7 of 25 residents identified as confused and ambulatory or mobile in a wheelchair without assistance on the 100 unit. [Residents #3, 30, 6, 53, 51, 25, and 50]</p> <p>Findings include:</p> <p>On 10/22/12 at 9:50 A.M., tour of the 100 unit was initiated with LPN #9.</p> <p>At that time, 7 of 25 residents were identified as being confused and ambulatory or mobile in a wheelchair without assistance.</p> <p>On 10/24/12 at 9:30 A.M., environmental tour was initiated with the Director of Plant Operations.</p> <p>On 10/24/12 at 10:00 A.M., a linen cart was observed with 3 bottles [4 ounces] of hand sanitizer and a medication cart was</p>	F0323	<p><b>F 323</b> Hand sanitizers were immediately removed to protect all residents that are determined to be at risk for the deficient practice. 10.24.12 All nursing staff was immediately in-serviced on the storage of hand sanitizers to ensure the deficient practice will not recur. Training on Guidelines for storage of hand sanitizer for all new employees through orientation and with yearly ongoing training programs will be monitored by the Assistance Director of Nursing/designee to ensure the deficient practice will not recur. The Director of Nursing/designee will monitor all nurses' medication carts and linen carts for improper storage of hand sanitizers during daily rounding 5 Xs week x 4 weeks, then 2 Xs week x 4 weeks and monthly times four weeks to ensure deficient practice will not recur. All results will be reported each month to QA committee for six months for review and changes to ensure the deficient practice will not recur. Date of Compliance: 11.09.12</p>	11/09/2012	

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	<p>observed with 1 bottle [4 ounces] of hand sanitizer.</p> <p>The linen cart and the medication cart were unattended by a staff member.</p> <p>At that time, in an interview, the Director of Plant Operations indicated he would remove the hand sanitizers.</p> <p>On 10/25/12 at 9:20 A.M., the Executive Director provided a "Material Safety Data Sheet" for the hand sanitizer.</p> <p>The "Material Safety Data Sheet" included, but was not limited to, "Product Name: Performance Instant Hand Sanitizer with Aloe... Hazardous Identification: May be harmful if swallowed..."</p> <p>3.1-45(a)(1)</p>				

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; 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 and record review, the facility failed to accurately label 2 of 2 open multiple dose insulin vials [Residents #39 and Resident #66] with an</p>	F0431	<p><b>F 431</b> Opened, undated vials of insulin for resident #66 and resident #39 were immediately disposed of and all medications carts were checked to</p>	11/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/25/2012
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	<p>open date.</p> <p>Findings include:</p> <p>On 10/24/12 at 9:30 A.M., environmental tour was initiated with the Director of Plant Operations.</p> <p>At that time, the medication room was observed to have 1 bottle of Humalog insulin labeled with Resident #66's name and 1 bottle of Novolog insulin labeled with Resident #39's name.</p> <p>Both vials of insulin were open without an open date.</p> <p>On 10/25/12 at 9:20 A.M., the Executive Director provided the facility's policy and procedure, "Preparation and General Guidelines" dated 3/1/07.</p> <p>The policy and procedure included, but was not limited to, "Policy: Vials and ampoules of injectable medications are used in accordance with the manufacturer's recommendation... The date opened and the initials of the first person to use the vial are recorded on multidose vials..."</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l)</p>		<p><b>ensure all open vials had date open stickers affixed.</b></p> <p><b>All residents with vials and ampoules of injectable medications have the potential to be affected by alleged deficiency.</b></p> <p><b>Assisted Director of Health Services/designee will audit all medication carts and medication prep room for open vials of medication without date open stickers which are dated and initialed 1xweekly x 4 weeks then 1x biweekly for 4 weeks then monthly x 3 month to ensure the deficient practice does not recur.</b></p> <p><b>Assisted Director of Health Services /designee will report audit findings to QA committee monthly x 6 months for review and changes to ensure the deficient practice will not recur.</b></p> <p><b>Date of Compliance: 11.15.12</b></p>		

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F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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 and record review, the facility failed to ensure 1 of 2 nursing</p>	F0441	<b>F 441 CNA # 3 was immediately inservice on guidelines for</b>	11/09/2012			

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	<p>staff performed proper hand hygiene after providing incontinent care to a resident. This deficient practice affected 1 of 1 resident observed during incontinent care in a sample of 14 residents reviewed. [Resident #11]</p> <p>Findings include:</p> <p>On 10/23/12 at 10:50 A.M., Certified Nursing Assistant [CNA] #3 and CNA #4 were observed performing incontinent care for Resident #11.</p> <p>Resident #11 was incontinent of urine. During incontinent care, CNA #3 was observed removing her gloves, exiting the room to the linen cart, and returning to Resident #11's bed with a fitted sheet. CNA #3 applied new gloves after returning from the linen cart. However, CNA #3 was not observed performing hand hygiene after her initial removal of gloves and trip to the linen cart that was located in the hallway.</p> <p>On 10/24/12 at 8:40 A.M., the Executive Director provided the facility policy and procedure, "Guidelines for Handwashing" dated 10/2004.</p> <p>The policy and procedure included, but was not limited to, "Purpose: Handwashing is the single most important</p>		<p><b>handwashing on 10.25.12. All residents have the potential to be affected by this practice. 10.24.12 All nursing staff were in-serviced on proper handwashing procedures. Handwashing observations will be conducted each shift of 3-5 employees: 3 times a week times 8 weeks, and then monthly time 4 months. All results will be reported to the QA committee times 6 months. Date of Compliance: 11.09.12</b></p>				

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	<p>factor in preventing transmission of infections... Procedure: Health Care Workers shall wash hands at times such as: After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc..."</p> <p>3.1-18(l)</p>			