

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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NAME OF PROVIDER OR SUPPLIER WOODLANDS AT RIVER TERRACE ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 CAYLOR BLVD BLUFFTON, IN 46714
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 3,4,5,6,7,10,11, 2014.</p> <p>Facility number: 003575 Provider number: 155726 AIM number: 200395060</p> <p>Survey Team: Martha Saull, RN, TC Sue Brooker, RD Julie Call, RN Virginia Terveer, RN</p> <p>Census bed type: SNF: 20 SNF/NF: 10 Residential: 64 Total: 94</p> <p>Census payor type: Medicare: 3 Medicaid: 7 Other: 84 Total: 94</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March</p>	F000000		

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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F000226 SS=D	<p>13, 2014 by Randy Fry RN.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure their policy and procedure for abuse indicated the required state agency was promptly notified of an allegation of abuse.</p> <p>Findings include:</p> <p>On 3/7/14 at 9:31 A.M., the Executive Director was interviewed. She indicated once the facility was made aware of an allegation of abuse, they do an initial investigation and then notify the State Agency within 24 hours of the date and time of the alleged event, if not sooner.</p>	F000226	<p>1. Community revised the Abuse and Neglect Policy effective 3/11/2014 to reflect that all allegations of abuse will be reported immediately, (immediately will be as soon as possible, but not to exceed 24 hours). See attachment A (River Terrace Estates Guidelines for Abuse, Neglect, Mistreatment, Prohibition and Misappropriation of Resident Property Policy). 2. All residents had the potential to be affected by the deficiency. New policy was created. 3. Community reviewed and revised policy and procedure. Staff in-service has been scheduled for 3/27/2014 for all staff members. Training will be done by outside consultant with LacyBeyl and Associates. 4. Executive Director and/or designee will be</p>	03/27/2014
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	<p>On 3/7/14 at 9:41 A.M., the Executive Director (ED) reviewed the facility policy and procedure for "Abuse, Neglect, Mistreatment Prohibition and Misappropriation of Resident Property Policy. The policy was dated 3/22/06. The ED indicated at the time, the policy did not indicate when the staff were to notify the ED and/or when the ED was to report to the state agency. Documentation was lacking of the state agency having been notified immediately of an allegation.</p> <p>On 3/7/14 at 10:58 A.M., the Administrator provided a copy of the facility policy and procedure for "State Reportable Unusual Occurrences Policy", which was dated 3/22/06. The procedure included, but was not limited to, the following: "Health Care Providers are required by law to report unusual occurrences within 24 hours of the occurrence to the Long Term Care Division..."the community must ensure that all alleged violations involving mistreatment, neglect or abuse...are reported immediately to the administration of the community and to other officials in accordance with State law through established procedures...COMMUNITY REPORTING AND</p>		responsible for the reporting of alleged abuse/neglect allegations to the state immediately, as defined by the new policy.				

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F000282 SS=D	<p>INVESTIGATION INSTRUCTIONS: The community must contact the ISDH (Indiana State Department of Health) by telephone...voicemail for incidents during business hours...or fax...or via email...within 24 hours upon determining a situation exists (or existed) that is reportable under these guidelines..." The Administrator indicated at this time, the above policy was the actual policy and procedure and the other policy and procedure provided earlier, "Abuse, Neglect ...Policy" was used for the training policy.</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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>A. Based on interview and record review, the facility to ensure a resident, whose oral fluid intake was documented as below the recommended daily amount, was monitored to attain the daily fluid intake recommendation for 1 of 1</p>	F000282	1. Resident #20's Careplan has been updated to include additional interventions regarding fluid intake. Resident #20 currently receives an average of 3060 ccs of fluid per day, (via water with all meals, juice and milk also offered, water pitcher filled three times per day,	03/31/2014

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	<p>residents reviewed for fluid intake. Resident #20</p> <p>B. Based on observation, interview and record review the facility failed to follow physician orders for a fluid restriction for 1 Resident (Resident #40).</p> <p>Findings include:</p> <p>A. On 3/5/14 at 2 P.M., the clinical record of Resident #20 was reviewed. The Doctors Progress note, dated 10/19/13, indicated the resident was a readmit to the facility. Diagnoses included, but were not limited to, the following: "Pneumonia, UTI (urinary tract infection), altered mental status, early dementia, depression..." The MDS (Minimum Data Set Assessment) dated 10/4/13, included, but was not limited to, the following: total cognition score of 10, which indicated moderately impaired cognition; and eating required supervision, oversight, encouragement or cueing.</p> <p>A Nutrition Assessment, dated 9/27/13, indicated the following: height 72 inches; weight 266.2 pounds and a total recommended total fluid intake of 2861 - 3019</p>		<p>beverages with snacks and meds). The resident's diagnosis has been updated to History of Dehydration. Resident will be monitored through the weekly Nutrition at Risk (NAR) meeting for 4 weeks or as long as monitoring is needed. 2. All new admissions from 1/1/14 to current were audited and none were found to have a diagnosis of dehydration. All dehydration assessments and Care plans were audited on 3/14/14 as to identify residents at risk for dehydration. All identified residents will be placed on NAR and hydration will be monitored thru the Intake record. 3. All admission charts will be audited for diagnosis of dehydration. If dehydration diagnosis is present, resident will be placed on Nutrition at Risk (NAR) for four weeks or more deemed by committee. Residents identified from 3/14/14 audit will also be placed on NAR and monitored for fluid intake for 4 weeks (or more if deemed necessary). Nursing in-service is scheduled and will be completed prior to 3/31/2014. 4. A revised Food Intake Record for meals and snacks has been created, (See attachment B - Food Intake Record). The Food Intake Record will be on blue paper for residents at risk. Documentation on MAR will include fluids passed with medications and amounts consumed per shift. On</p>		

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	<p>cc/day.</p> <p>A Dehydration Risk Assessment, dated 9/27/13 included the following: total score was 3. The form indicated a total score above 8 represents high risk.</p> <p>A bowel and bladder Assessment, dated 9/27/13, included but was not limited to, the following: "Pattern of fluid intake: WNL (within normal limits)."</p> <p>An "Intake and Output Record" dated from 9/28/13 - 10/4/13 included, but was not limited to, the following: each of the 3 shifts was listed, and included the following totals: meal fluids, snack fluids, med (medication) pass fluids. The total of each type of fluid was calculated. The total intake for each day was not documented on the form. When calculated, the daily totals were as follows: 1200 cc, 1200 cc, 1080 cc, 1620 cc, 1320 cc, 1200 cc, 1440 cc. The area at the bottom of the form titled "Weekly Intake and Output Evaluation" was left blank for the following information: avg (average) 24 hour intake, recommended intake and difference intake.</p> <p>An admission History and Physical</p>		<p>admission, resident will have one week of I&O recorded. Those who have a diagnosis of dehydration will have Intake Record completed for at least three more weeks (or as deemed necessary by NAR committee), (see attachment C - Intake Record). This will include fluid intake such as meals, snacks, and medication pass. Resident Care Plans will be updated with interventions as needed. The NAR policy will be updated to include residents at risk for dehydration, (See attachment D - NAR Policy). Residents will be followed on Quality Assurance Program quarterly. 1. Upon notification from surveyor regarding deficient practice of Resident #40; community notified doctor to obtain an order for 240 cc's per meal, 240 cc's 3x per day, (10 am, 2 pm and HS); and 360 with med pass or bedside. This information was also updated on the MAR. On 3/5/2014 the physician discontinued the fluid restriction. 2. All resident charts were audited 3/14/14 and the community currently has no other residents with a doctors order for a fluid restriction. No other residents were affected by this deficient practice. 3. Upon admission or new physician order for fluid restriction, the registered dietitian and/or certified dietary manager along with the Director of Nursing will create a specific</p>		

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	<p>when the resident was admitted to (name of hospital), dated 10/9/13, included but was not limited to, the following: "Chief complaint: found down on the floor and incontinent of urine...He has poor oral intake and reports that he has to urinate constantly...Past medical history...benign essential hypertension...chronic kidney disease...Medications:...Lasix (diuretic) 20mg po (by mouth) bid (twice a day)...The patient reports his appetite is puny...Assessment and Plan...Chronic Kidney Disease stage II. Glomular Filtration Rate is 29. The patient is close to stage V. He is possibly a little bit dry. He is being hydrated. His initial blood pressure was 70/50. He may need his medications adjusted."</p> <p>A Hospitalist Admit Note, dated 10/9/13, included but was not limited to, "CKD (chronic kidney disease) Stage 4, Pt (patient) possible a little dry will hydrate res (resident) night and recheck. (sic)"</p> <p>A hospital consultation, dated 10/11/13, included, but was not limited to, the following information: "...patient was found on the floor incontinent of urine. His blood pressure was 70/50...The patient</p>		<p>fluid restriction Care Plan specifying cc's given at meals, snacks, at bedside and during medication pass. All fluid restriction residents will be monitored through NAR while restriction is in place, (See attachment D - NAR Policy). 4. If a resident is admitted with a fluid restriction or when the community receives and updated order on a resident, nursing will communicate the fluid restriction to the Certified Dietary Manager and the Director of Nursing through the Diet Change Form, (see attachment E - Diet Change Form). This form will be used to initiate the monitoring through NAR.</p>	

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	<p>was found to be dehydrated with stage IV chronic kidney disease. He has received IV fluids and is much improved today...Laboratory Studies...Admission BUN (Blood urea nitrogen) is 52 with a creatinine of 2.4, and a GFR of 24; After IV (intravenous) fluids, BUN is 52 with a creatinine of 1.9 and a GFR of 34...Impression:...Stage IV chronic kidney disease improving to stage III on IV fluid resuscitation."</p> <p>A physician progress note from the (name of hospital) dated 10/17/13 included, but was not limited to, the following: "Assessment and plan: Mental Status change with obtundation. This is currently resolved, etiology unknown..."</p> <p>A Dehydration Risk Assessment, dated 10/19/13 included the following: total score was 6. The form indicated a total score above 8 represents high risk. The back of the form indicated for this date the following: "does not appear to be at risk at this time. Staff offers fluids."</p> <p>The Intake and Output Record dated 10/19/13 - 10/25/13 included the following totals: 1320 cc for 4 days, 1600ccs, 1380ccs, 1080 cc. Again, the weekly intake and output</p>						

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	<p>evaluation area at the bottom of the form was left blank for average 24 hour intake, recommended intake and difference intake.</p> <p>A (name of hospital) discharge summary, dated 10/18/13 included, but was not limited to, the following: "Discharge Diagnosis:...Chronic Kidney Disease, Stage III, Dehydration...Discharge medications:...Lasix discontinued...Overall, I think the cause of this was multiple medications that the patient was on for his blood pressure and Lasix. It caused his kidneys to go from Stage III to Stage IV. After hydration, his renal function improved."</p> <p>A Dietary Progress note dated 10/25/13 included, but was not limited to, the following: "hospitalized 10/9/13 - 10/18/13...able to select meals and feeds self with supervision and set up in unit DR (dining room)...appetite is good...fluids of 240-360cc/meal..."</p> <p>A Dietary Progress note dated 11/14/13 included, but was not limited to, the following: "...appetite is good with fluid of 240-360cc/meal...will continue to</p>			

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	<p>monitor..."</p> <p>A Dietary Progress note dated 12/12/13 included, but was not limited to, the following: "...fluids of 180-360cc/meal...will continue with present goals."</p> <p>A Dietary Progress note dated 1/9/14 included, but was not limited to, the following: "...fluids of 240-420cc/meal...will continue with present goals."</p> <p>A plan of care, dated 11/19/13, addressed the following problem: "(name of resident) demonstrates altered level of cognitive function due to dx (diagnosis) of dementia, as evidenced by difficulty with memory at times..." Interventions included, but were not limited to, "Supervise and assist with all decision making."</p> <p>A plan of care, dated 11/19/13, addressed the following problem: "(name of resident) is at risk for weight changes and dehydration r/t (related to) DX (diagnosis) of early dementia, depression and diuretic use, recent hospital stay." Interventions included, but were not limited to, the following: "...Assess and document resident's dietary</p>			

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	<p>history, patterns of ingestion...dietary consult as needed..."</p> <p>A plan of care, dated 11/19/13, addressed the following problem: "Dehydration/Fluid Maintenance, (name of resident) has a potential for fluid volume deficit related to Dx (diagnosis) of dementia, depression and diuretic use." Interventions included, but were not limited to, the following: "Assess for signs/symptoms of dehydration; assess client's understanding of the reasons for maintaining adequate hydration and methods for reaching goal of fluid intake; encourage fluids..."</p> <p>A Dehydration Risk Assessment, dated 1/15/14 included the following: total score was 6. The form indicated a total score above 8 represents high risk. The back of the form indicated for this date the following: "Resident at moderate risk with score of 5. Fluids are encouraged and accepted well at meals, med pass, hydration pass and room visits."</p> <p>On 3/6/14, at 11:00 A.M., the DON was interviewed. She indicated the dehydration Risk Assessments were</p>				

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	<p>done quarterly, with readmission and/or admission and or significant changes.</p> <p>On 3/6/14 at 11:07 A.M., the DON (Director of Nursing) was interviewed. She indicated the facility just started the NAR (nutrition at risk) meetings last month. She indicated the NAR committee met for the first time in January to discuss the NAR program. She indicated the NAR team met in February and this resident was not reviewed.</p> <p>The DON indicated the facility stopped the I and O (intake and output) for this resident on 10/26/13, as they do and I and O on residents for 7 days after admission and/or readmission. The DON indicated they would ask staff if they were offering snacks, does the resident realize his pitcher is at the bedside. She indicated this form, the I and O, was a total picture of what fluid the resident was taking in. At the time, the DON indicated if the resident has signs and symptoms of dehydration, they would look at the resident. She stated as long as the resident accepts drinks and gets fluids on his own, the CNAs and servers would not report this to</p>			
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	<p>anyone. The DON indicated if a resident has cognitive changes or a decline and needs help, "you zone in on those people." She indicated the resident is able to ask for fluids and accept differently than someone who isn't able to.</p> <p>Regarding who monitors the fluid intakes of the residents, the DON indicated if a CNA (Certified Nursing Assistant) and/or servers (dietary staff who deliver beverages and meal trays to the residents in the dining room) "observed" if the resident didn't drink what they usually do at meals, they (the CNA and/or server) would report the observation to either a nurse or the FSM (Food Service Manager).</p> <p>On 3/6/14 at 10:30 A.M., the Dietician was interviewed. She indicated the following: this was a new resident to the facility but his appetite was pretty good. She indicated the resident had dementia, chronic kidney disease and behaviors and got to choose what to eat and drink. She indicated the resident did have chronic kidney disease so his BUN and creatinine would be high. She indicated she looked at the total fluid intake of the resident per meal. The Dietician</p>			

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	<p>indicated she didn't total the daily fluid intakes because it is not a true total and didn't include the other fluids the resident was taking, for example with med pass. She indicated the "true total" of the resident ' s intake was on the Intake and Output form.</p> <p>The Dietician indicated at the time, when the resident returned from the hospital on 10/19/13, the facility did not implement any new interventions in regards to the resident's hydration. She indicated residents in a Long Term Care facility should have at least a minimum of 1500 ccs daily.</p> <p>On 3/6/14 at 11:25 A.M., the DON was interviewed. She indicated dehydration assessments were done quarterly, admission, readmission and with a significant change. The DON indicated staff was offering the resident snacks, and he had a pitcher with water available at his bedside. The DON indicated if the resident had signs and symptoms of dehydration they would "look at the resident." She indicated as long as the resident accepted drinks and got fluids on his own, the CNAs would not report the resident's intake as a problem. She indicated if there were</p>			

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	<p>cognitive changes or a decline in his condition and would require assistance, "those are the ones you zone in on." She indicated this resident was able to ask for fluids and accept them differently than a resident who wasn't able to.</p> <p>The DON indicated when the resident returned from the hospital, dehydration was not listed as a diagnosis. The DON indicated the resident drank independently and had the potential for dehydration.</p> <p>On 3/6/14 at 11:35 A.M., the policy and procedure for NAR (Nutrition at Risk) policy was received from the Administrator. This policy was dated 1/16/14. The objective documented on the policy included: "To identify residents and monitor their progress towards acceptable parameters of body weight and protein levels unless their clinical condition will not allow them to reach their ideal body weight."</p> <p>On 3/7/14 at 9:15 A.M., the DON provided the following documentation: "Daily Basic Fluid Provided" a total of 1380cc (water with meals, juice offered with breakfast and milk offered with breakfast and lunch); 32 oz full</p>				

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	<p>water pitcher in each shift (total 960); and total of 720cc of beverages provided with snacks. These fluids provided total 3060 ccs. "In addition to above: hot chocolate at breakfast, lunch and supper. Gets milk, coffee, juice typically every A.M..staff reports he requests extra fluids thru out (sic) day...Above does not include liquid contents in food."</p> <p>Documentation was lacking to indicate the following: the resident was on the initial 7 day I and O record (9/28 - 10/4/13) and had fluid intakes per meal ranging from 240 cc - 480 ccs. These intakes, when added to the snack fluids and med pass fluids had totals which ranged from 1080 cc -1620 ccs. When the resident returned from the hospital on 10/19/13, the 7 day I and O record had fluid intakes per meal ranging from 240 cc - 480ccs. These intakes, when added to the snack fluids and med pass fluids had totals which ranged from 1080 ccs - 1600 ccs. The meal intake records for October 2013 - December 2013 were reviewed and indicated fluid intakes per meals ranged from 120cc - 480cc, with one meal intake on 11/26/13 documented at 600ccs. The meal</p>			

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	<p>intake records for January 2014 - March 2014 were reviewed and indicated fluid intakes per meals ranged from 120cc - 480cc, with one meal intake on 3/1/14 documented as 550ccs.</p> <p>The documented daily fluid intake totals were consistently below the dietary recommended minimum daily fluid intake of 2861ccs.</p> <p>B. Review of the clinical record for Resident #40 on 3/5/14 at 9:37 a.m., indicated the following: diagnoses included, but were not limited to, edema, dependent edema, renal insufficiency, depression, dementia, dementia of Alzheimer's type with associated mood disorder, and anxiety.</p> <p>A physician's order for Resident #40, dated 7/23/13, indicated she received a No Added Salt (NAS) diet with 1800 cc (cubic centimeter)/24 hr (hour) fluid restriction. The orders also indicated she received Hydrochlorothiazide (diuretic) 12.5 mg (milligrams) on Monday, Wednesday, Friday, Saturday, and Sunday for edema and Lasix (diuretic) 20 mg daily for edema (started on 7/17/13).</p>			

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	<p>A Dehydration Risk Assessment for Resident #40 indicated the following: on 9/19/13, "...Resident is at very low risk for dehydration. Is able to request fluids as needed...."; and on 12/16/13, "...Resident at low risk... Able to utilize bedside pitcher et (and) request fluids as needed...."</p> <p>A Dietary Progress Notes for Resident #40, dated 9/12/13, indicated she received a NAS diet. The note also indicated she consumed 120 cc's to 360 cc's of fluid at mealtime. The note did not indicate Resident #40 was on a fluid restriction or the amount of fluids dietary could provide in a 24 hour period.</p> <p>A Dietary Progress Notes for Resident #40, dated 12/12/13, indicated she continued on a NAS diet. The note also indicated she consumed 120 cc's to 480 cc's of fluid at mealtime. The note did not indicate Resident #40 was on a fluid restriction or the amount of fluids dietary could provide in a 24 hour period.</p> <p>A Dietary Progress Notes for Resident #40, dated 2/27/14, indicated she continued on a NAS diet. The note also indicated staff</p>			

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	<p>reported edema and she chose to drink more than the 1800 cc restriction. The note did not indicate the amount of fluids dietary could provide in a 24 hour period.</p> <p>Review of the Meal Intake Records for Resident #40, indicated the amount of fluid consumed with meals. The record did not indicate the amount of fluids dietary could provide in a 24 hour period.</p> <p>Review of the Medication Administration Records (MAR) for Resident #40, indicated the amount of fluid consumed during the 10-6 shift medication pass, the 6-2 shift medication pass, and the 2-10 shift medication pass. The MAR did not indicate the amount of fluids nursing could provide in a 24 hour period.</p> <p>A facility Care at a Glance sheet for use by the Certified Nursing Assistants during the first three days of the survey, indicated Resident #40 was on a 1500 ml fluid restriction. The sheet did not indicate the amount of fluids nursing could provide on the 10-6 shift, the 6-2 shift, and the 2-10 shift.</p> <p>There was no documentation in the clinical record for Resident #40</p>			

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	<p>defining the total amount of fluids provided by nursing and dietary in a 24 hour period. There was also no documentation in the clinical record indicating the total amount of fluids she consumed from nursing and dietary in a 24 hour period.</p> <p>A facility care plan for Resident #40, with a start date of 9/18/13, indicated the problem area of resident at risk for weight loss related to diuretic use and diagnosis of dementia and depression. Approaches to the problem included, but were not limited to, Regular Diet with 1800 cc fluid restriction, allow choices as able, fluid of choice at bedside, and monitor food consumption The care plan did not indicate the distribution of 1800 cc's of fluid between dietary and nursing in a 24 hour period. The care plan also did not indicate her consumption of fluids would be monitored.</p> <p>A facility care plan for Resident #40, with a start date of 9/18/13, indicated the problem area of resident has fluid volume excess related to renal insufficiency and is on a fluid restriction but is non compliant. Approaches to the problem included, but were not</p>			

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	<p>limited to, encourage to follow fluid restriction. The care plan did not indicate the distribution of 1800 cc's of fluid between dietary and nursing in a 24 hour period. The care plan also did not indicate her consumption of fluids would be monitored.</p> <p>During an observation on 3/3/14 at 9:00 a.m., an 8 ounce glass of water and an 8 ounce mug of coffee were observed on the over the bed table next to the bed of Resident #40.</p> <p>During an observation of the lunch meal on 3/3/14 at 11:15 a.m. in the dining room, Resident #40 was observed to have an 8 ounce glass of water and an 8 ounce mug of coffee.</p> <p>During an observation of the lunch meal on 3/4/14 at 11:32 a.m. in the dining room, Resident #40 was observed to have an 8 ounce glass of water and an 8 ounce mug of coffee.</p> <p>Certified Nursing Assistant #2 was interviewed on 3/4/14 at 10:47 a.m. During the interview she indicated Resident #40 was given an 8 ounce glass of ice water each shift.</p>			

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	<p>The Certified Dietary Manager (CDM) was interviewed on 3/5/14 at 11:15 a.m. During the interview she indicated dietary provided Resident #40 with 240 cc's of fluid at each meal.</p> <p>LPN #3 was interviewed on 3/5/14 at 2:00 p.m. During the interview she indicated nursing recorded the amount of fluids a resident consumed during each medication pass on the MAR. She also indicated the MAR did not indicate how much fluid was allowed for nursing on each shift. She did not indicate the MAR also included the amount of ice water consumed by Resident #40 during each shift.</p> <p>LPN #4 was interviewed on 3/5/14 at 3:30 p.m. During the interview she indicated she usually gave 90 cc's of water with medication pass.</p> <p>The Registered Dietitian was interviewed on 3/6/14 at 8:40 a.m. During the interview she indicated a fluid distribution plan had not been developed for Resident #40.</p> <p>A policy on fluid restriction was requested from the Director of Nursing on 3/5/14 at 3:40 p.m.</p>			

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F000323 SS=E	<p>The CDM was interviewed on 3/6/14 at 9:45 a.m. During the interview she indicated the facility did not have a policy on fluid restrictions.</p> <p>3.1-35(g)(2)</p> <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 observation, interview and record review the facility failed to ensure personal hygiene items and hand sanitizer were kept secured from 1 of 1 confused, ambulatory and wandering resident (Resident #38). The facility also failed to ensure resident mattresses and bed frames for 5 of 30 occupied beds were installed correctly to prevent potential safety hazards. (Resident #25, Resident #18, Resident #40, Resident #45, and Resident #10).</p>	F000323	<p>1. Upon notification of deficient practice, all personal hygiene items were removed from resident #38's bathroom as well as the hand sanitizer placed on the nurses desk, (3/6/2014 and 3/7/2014). 2. All resident bathrooms/rooms were inspected and no other residents were found to have this deficient practice. There were no other personal care items left in common areas.</p> <p>3. Staffing in-service will be completed by 3/27/2014</p>	03/31/2014			

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	<p>Findings include:</p> <p>1. Review of the clinical record for Resident #38 on 3/4/14 at 2:28 p.m., indicated the following: diagnoses included, but were not limited to, dementia Alzheimer's type advanced with sad mood, generalized anxiety disorder, and behavioral and psych symptoms of dementia.</p> <p>A Minimum Data Set (MDS) assessment for Resident #38, dated 12/2/13, indicated a score of 3 out of 15 on the Brief Interview for Mental Status, indicating a severe cognitive impairment. The MDS also indicated she required supervision-oversight with set-up help only from staff for walking in her room and on the unit.</p> <p>A Doctor's Progress Notes for Resident #38, dated 12/12/13, indicated she was confused and wandering.</p> <p>During an observation of the bathroom for Resident #38 and her roommate on 3/3/14 at 2:24 p.m., the following items were observed on top of the counter surrounding the sink: a pump bottle of Bath & Body Works body lotion, a jar of</p>		<p>regarding safety of personal products with warning labels left within residents rooms with Alzheimer's type dementia. The community will not allow such products with warning labels to be left in common area's. 4. Residents with a BIMS score of 7 or less will have their room monitored daily for 2 weeks, once per week for 2 weeks and then monthly for 2 months by Director of Nursing and/or designee. (See attachment F - monitoring tool for "warning label" products.) 1. Residents identified to be affected by the deficient practice, (#25, 18, 40, 10, and 45) all had their mattresses changed, headboard added (Resident #10), or the headboard adjusted to fit, ensuring that a gap of no more than 4 3/4 inches existed. 2. Director of Plant Operations measured all 30 resident mattresses, including those that were found to be deficient, and found no other residents to be affected by deficient practice. 3. Community created a Bed Safety Policy (see attachment G - Bed Safety Policy). 4. All mattresses will be inspected quarterly for correct spacing to ensure proper spacing is maintained.</p>				

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	<p>Pond's cold cream, a bottle of Act Restoring mouthwash, a tube of Jergen's Daily Moisturizing Lotion, and a pump bottle of clear antibacterial liquid hand soap.</p> <p>During an observation of the bathroom for Resident #38 and her roommate on 3/4/14 at 9:30 a.m., the following items were observed on top of the counter surrounding the sink: a pump bottle of Bath & Body Works body lotion, a jar of Pond's cold cream, a bottle of Act Restoring Mouthwash, a tube of Jergen's Daily Moisturizing Lotion, and a pump bottle of clear antibacterial liquid hand soap.</p> <p>During an observation of the bathroom for Resident #38 and her roommate on 3/4/14 at 4:25 p.m., the following items were observed on top of the counter surrounding the sink: a pump bottle of Bath & Body Works body lotion, a jar of Pond's cold cream, a bottle of Act Restoring Mouthwash, a tube of Jergen's Daily Moisturizing Lotion, and a pump bottle of clear antibacterial liquid hand soap.</p> <p>During an observation of the bathroom for Resident #38 and her roommate on 3/5/14 at 10:02 a.m.,</p>			
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	<p>the following items were observed on top of the counter surrounding the sink: a bottle of Act Restoring Mouthwash and a pump bottle of cleat antibacterial liquid hand soap. The pump bottle of Bath & Body Works body lotion, the jar of Pond's cold cream and the tube of Jergen's Daily Moisturizing Lotion had been removed from the counter.</p> <p>During an observation of the bathroom for Resident #38 and her roommate on 3/6/14 at 9:30 a.m., the following items were observed on top of the counter surrounding the sink: a bottle of Act Restoring Mouthwash and a pump bottle of clear antibacterial liquid hand soap. The pump bottle of Bath & Body Works body lotion, the jar of Pond's cold cream and the tube of Jergen's Daily Moisturizing Lotion had been removed from the counter.</p> <p>Throughout the days of the survey, from 3/3/14 through 3/7/14, a pump bottle of McKesson Instant Hand Sanitizer was observed on top of the counter at the nursing station providing easy access to residents.</p> <p>A Material Safety Data Sheet (MSDS) for the Act Restoring Mouthwash, provided by the</p>			

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	<p>Executive Director on 3/6/14 at 1:25 p.m., indicated the product contained 11% Ethyl Alcohol. First Aid Measures indicated: In case of contact with eyes, rinse immediately with plenty of water for 15 minutes and seek medical attention. In the case of skin irritation or allergic reactions, discontinue use. If irritation persists, seek medical attention. In case of ingestion, seek immediate medical attention and show the label.</p> <p>An MSDS for the clear antibacterial liquid hand soap, provided by the Executive Director on 3/6/14 at 1:30 p.m., indicated: May cause minor irritation of the eyes and mucous membranes. Possible nausea if ingested in sufficient amounts.</p> <p>An MSDS for the Bath & Body Works body lotion, provided by the Executive Director on 3/6/14 at 2:50 p.m., indicated: May cause eye irritation. Immediately flush eyes out with cold water. If irritation persists seek medical attention; may be harmful if swallowed. If swallowed seek medical attention.</p> <p>An MSDS for the Pond's Cold Cream, provided by the Executive Director on 3/6/14 at 2:50 p.m.,</p>			

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	<p>indicated: May cause redness or irritation to the eyes. Rinse thoroughly with water; may cause nausea, vomiting and diarrhea.</p> <p>An MSDS for the Jergen's Daily Moisturizing Lotion, provided by the Executive Director on 3/6/14 at 2:50 p.m., indicated: Avoid contact with eyes. If this occurs, flush well with water. If irritation persists more than one hour, consult a physician. In the event of ingestion, contact a poison control center or a physician.</p> <p>An MSDS for the McKesson Instant Hand Sanitizer, provided by the Executive Director on 3/6/14 at 3:30 p.m., indicated: Do not get into eyes; possible watering, burning and redness; may be harmful if swallowed; possible gastrointestinal irritation or disturbance.</p> <p>A facility care plan for Resident #38, with a start date of 10/31/13, indicated the problem area of resident demonstrates altered level of cognitive function due to diagnosis of behavioral and psych symptoms of dementia. Approaches to the problem included, but were not limited to, supervise and assist with all decision making.</p>						

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	<p>The Director of Nursing was interviewed on 3/6/14 at 1:25 p.m. During the interview she indicated personal care items should not be left out within view and easy reach for a resident who is confused.</p> <p>The Director of Nursing was interviewed on 3/7/14 at 9:16 a.m. During the interview she indicated the facility did not have a policy on the storage of chemicals or potentially harmful products.</p> <p>2. Review of the clinical record for Resident #25 on 3/5/14 at 8:57 a.m., indicated the following: diagnoses included, but were not limited to, frailty, dementia, adult failure to thrive, and osteoporosis.</p> <p>A Minimum Data Set (MDS) assessment for Resident #25, dated 1/10/14, indicated a score of 5 out of 15 on the Brief Interview for Mental Status, indicating sever cognitive impairment. The MDS also indicated she required extensive assistance with the physical assistance of 1 staff for bed mobility. The MDS further indicated her balance was not steady during transitions.</p> <p>A Fall Assessment for Resident #25,</p>			

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	<p>dated 2/16/14, indicated she had intermittent confusion/disorientation, a history of falls, a balance problem when standing, a balance problem with sitting to standing, a balance problem while walking, was jerking or unstable when turning, required a walker, took medications that could contribute to falls, and had 1-2 predisposing diseases which could contribute to falls. The assessment also indicated she was considered high risk for falls.</p> <p>An undated Fall Prevention Intervention Care Plan found in the clinical record for Resident #25, indicated to visually check the resident every two hours, or more frequently as determined by care team, answer call light promptly, remind the resident to ask for assistance, and keep the call light and water within reach.</p> <p>During an observation of the 100 Hall on 3/4/14 at 10:49 a.m., the mattress on the bed of Resident #25 was observed to have a large gap, 2.5 inches, between the top of the mattress and the headboard of the bed and a large gap, 4.25 inches, between the bottom of the mattress and the footboard of the bed.</p>						

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	<p>3. Review of the clinical record for Resident #18 on 3/5/14 at 2:35 p.m., indicated the following: diagnoses included, but were not limited to, osteoporosis, mild dementia, mood disorder, and insomnia.</p> <p>A Minimum Data Set (MDS) assessment for Resident #18, dated 1/3/14, indicated a score of 3 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The MDS also indicated she was totally dependent on staff with the physical assistance of 2 staff for bed mobility. The MDS further indicated her balance was not steady during transitions.</p> <p>A Fall Risk Assessment for Resident #18, dated 2/22/14, indicated she was disoriented x (times) 3 at all times, had a history of falls, took medications that could contribute to falls, and had 1-2 predisposing diseases which could contribute to falls. The assessment also indicated she was considered high risk for falls.</p> <p>A facility care plan for Resident #18, with a start date of 1/4/14, indicated the problem area of Hospice services with terminal prognosis related to frailty. Approaches to the</p>			

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	<p>problem included, but were not limited to, Hospice provides specialty mattress.</p> <p>During an observation of the 100 Hall on 3/4/14 at 10:42 a.m., the mattress on the bed of Resident #18 was observed to have a large gap, 3 inches, between the top of the mattress and the headboard on the bed and a large gap, 2.5 inches, between the bottom of the mattress and the footboard of the bed.</p> <p>4. Review of the clinical record for Resident #40 on 3/5/14 at 9:37 a.m., indicated the following: diagnoses included, but were not limited to, depression, dementia, dementia of Alzheimer's type with associated mood disorder, and anxiety.</p> <p>A Minimum Data Set (MDS) assessment for Resident #40, dated 12/16/13, indicated a score of 13 out of 15 on the Brief Interview for Mental Status, indicating she was cognitively intact. The MDS also indicated she required supervision-oversight with set-up help only for bed mobility. The MDS further indicated her balance was not steady during transitions.</p> <p>A Fall Risk Assessment for Resident</p>			

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	<p>#40, dated 1/22/14, indicated she had intermittent confusion/disorientation, had poor vision, was jerking or unstable when turning, required an assistive devise, took medications that could contribute to falls, and had 1-2 predisposing diseases which could contribute to falls. The assessment also indicated she was not considered high risk for falls.</p> <p>During an observation of the 100 Hall on 3/5/14 at 10:50 a.m., the mattress on the bed of Resident #40 was observed to have a large gap, 2 inches, between the top of the mattress and the headboard of the bed and a large gap, 3 inches, between the bottom of the mattress and the footboard of the bed.</p> <p>5. Review of the clinical record for Resident #10 on 3/4/14 at 2:40 p.m., indicated the following: diagnoses included, but were not limited to, Parkinson's Disease, tremors, dementia, arthritis, neurogenic bladder with chronic incontinence,</p>						

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	<p>UTI (urinary tract infection), depression, history of costochondritis.</p> <p>A Minimum Data Set (MDS) assessment for Resident #10, dated 12/9/13, indicated a score of 7 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The MDS also indicated she required extensive assistance with the physical assistance of 1 staff for bed mobility. The MDS further indicated her balance was not steady during transitions and only able to stabilize with human assistance.</p> <p>During an observation of Resident #10's bed, on 3/3/14 at 11:40 a.m., the bed's headboard was missing and an over bed trapeze was attached to the head (top) of the bed frame. At the top of the mattress, two 1 inch x 1 inch L shaped metal brackets projected 3 inches above the mattress surface. The L-brackets were intended to be used to attach the headboard to the bed frame, which was not observed in place at this time (the headboard).</p> <p>Interview with ED (Executive Director) and DON (Director of Nursing) on 3/3/14 at 4:00 p.m.,</p>			
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	<p>indicated they were not aware the headboard was removed from the bed and the L-bracket were exposed above the level of the mattress. ED indicated the maintenance staff would remove the L-brackets right away.</p> <p>During an observation of Resident #10's bed on 3/4/14 at 8:50 a.m., the L-brackets had been removed from the bed frame. The space between the mattress and trapeze frame measured 2.5 inches and the space between the mattress and footboard was 3.5 inches. The mattress could move freely on the bed frame and the total space between mattress and the head and foot boards was 6 inches.</p> <p>Interview with ED on 3/4/14 at 11:40 a.m., indicated she was not aware Resident #10's bed had too large of a gap between the mattress and the headboard and footboard since the L-brackets were removed. She indicated the Maintenance staff had measured all of the facility's beds for large gaps of the mattresses.</p> <p>Interview with ED on 3/4/14 at 3:40 p.m., indicated she was not aware of a facility policy for measurements of the mattress on the bed frame. She</p>				

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	<p>indicated Maintenance ordered mattresses for the facility's beds and was responsible to make sure the mattress fit the bed frame correctly.</p> <p>Interview with Maintenance Director on 3/5/14 at 9:50 a.m., indicated four mattresses were too short for the bed frame. He indicated 3 of the 4 mattresses were brought into the facility by the Hospice agency and the other bed belonged to the facility. He indicated the facility had one bed with a long frame and the mattress was too short for that bed. He also indicated the facility did not have a policy to monitor the mattresses for sizes, large gaps or monitoring of mattresses brought into the facility. The Maintenance Director indicated the facility had 2 types of beds in the facility and he provided the Manufacture's Manuals for the beds and mattresses.</p> <p>Review of the Manufacture's Manuals for the facility's beds provided by Maintenance Director on 3/6/14 at 3:00 p.m., indicated the following; - The (proper noun) Bed, dated 6/8/2001 indicated the following: "...SAFETY SUMMARY...Warning/Cautions...hazards or unsafe practices that could</p>			

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	<p>result in personal injury....Specifications: 76 inch Bed -Length of Mattress Surface 75.75 inches and 80 inch Bed -Length of Mattress Surface, 79.75 inches...." -The EZE-LOK Bed, dated 5/18/2000, indicated the following: "...SAFETY SUMMARY...Warning/Cautions...hazards or unsafe practices that could result in personal injury....Specifications: 76 inch Bed -Length of Mattress Surface 75.75 inches and 80 inch Bed -Length of Mattress Surface, 79.75 inches...."</p> <p>6. On 3/3/14 at 11:50 A.M., the bed of Resident #45 was observed. Bilateral side rails were not observed to be up. The Resident's mattress was observed to be unoccupied, at the time, and in the flat position, the top of the mattress was observed to be 6 1/4 inches from the top of the mattress to the headboard. The mattress was also able to be moved about freely on the bed frame.</p> <p>On 3/3/14 at 2 P.M., the clinical Record of Resident #45 was reviewed. Diagnoses included but were not limited to, the following: History of Parkinson's Disease. A siderail evaluation was dated</p>				

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	<p>12/30/13 and indicated the following: "Resident utilize 1/2 side rails at HOB (head of bed) for bed mobility and increase independence."</p> <p>On 3/3/14 at 4 P.M., the Executive Director was made aware of the concerns with the large gaps between the mattress and the headboards and the "L" shaped brackets exposed on the bed of Resident #10. The Executive Director indicated she understood the concerns and would correct the concerns immediately.</p> <p>On 3/4/14 at 8: A.M., the Executive Director (ED) indicated they had removed the metal posts from the head of the resident's bed and they had replaced two of the mattresses which were identified as two short for the beds. The ED indicated two of the residents were Hospice patients. She indicated the facility adapted the current mattress to properly fit the bed frames until Hospice can bring the new mattresses that fit properly.</p> <p>On 3/4/14 at 3:30 P.M. the Executive Director was interviewed. She indicated the Maintenance Man placed the mattresses and the bed frames, so it was maintenance's</p>				

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	<p>responsibility to ensure the mattresses had a proper fit with the bed frame.</p> <p>On 3/5/14 at 9:50 A.M., the Maintenance Man (MM) was interviewed. He indicated three of the mattresses were brought to the facility by Home Health Care (HHC) and/or Hospice. He indicted the 4th mattress belonged to facility. He indicated usually HHC brings the entire bed, mattress and frame, but that did not happen this time.</p> <p>The MM indicated he modified the current occupied beds by moving the headboards forward about 2 1/2 inches to reduce the gap between the top of the mattress and the head of the bed. The MM indicated HHC/Hospice brought in two longer mattresses to replace those that were short. The MM indicated the FDA (Federal Drug Administration) standard for spaces between the mattresses and the bed frames was 4 3/4 inches. Stated FDA showed zone 7 was the entrapment risk, which is at the HOB. The MM stated when this all came out in 2006 and 2007 they checked side rails and mattresses. He stated it will be his intent before a mattress ever comes in the facility will make sure it fits the</p>			
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	<p>bed.</p> <p>On 3/5/14 at 10:15 A.M., the Executive Director was interviewed. She indicated the facility was going to develop an internal policy for the acceptable spaces/gaps on resident beds. She indicated the facility was also going to get a block of wood, 4 3/4 inches wide to use as a reference for acceptable spaces/gaps on beds to be compliant with federal regulations.</p> <p>On 3/5/14 at 11:41 A.M., the Administrator provided a copy of the facility "Standards and Guidelines" for Bed Safety. This form was dated 3/10/06. The Administrator indicated this was what he developed as a tool to monitor bed mattress/spaces. This document included, but was not limited to, the following: "At time of purchase of new mattresses, Plant Operations Director will inspect for proper spacing according to the FDA guideline above; the Director of Nursing will notify Plant Operations Director of any vendor replacement mattresses being placed. Plant Operations Director will inspect for proper spacing according to FDA guidelines above. All mattresses will be inspected quarterly for correct</p>						

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	<p>spacing to ensure proper spacing is maintained."</p> <p>The document "Guidance for Industry and FDA (Food and Drug Administration) Staff, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" dated 3/10/06 included, but was not limited to, the following: "FDA is therefore using a head breadth dimension of...4 3/4 inches as the basis for its dimensional limit recommendations..."</p> <p>3.1-45(a)(1)</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 ensure open dates were marked on</p>	F000431	<p>1. All eye drop containers found to be deficient were immediately discarded. The Novolog was discarded as well the OTC medications. No other residents</p>	03/31/2014			

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	<p>6 containers of eye drops, Novolog was not discarded and was used after the expiration date and labels were not affixed to OTC (Over the Counter) medications and treatment containers for 1 of 2 medication carts and 1 of 1 treatment carts, potentially affecting (Residents #33, #17, #19, #25, #12, and #6)</p> <p>Findings include:</p> <p>During an observation of the Medication and Treatment carts on 3-3-2014 from 10:47 a.m. to 11:10 a.m. with QMA #5, the following was observed:</p> <ul style="list-style-type: none"> -No open date was on Resident #33's container of artificial tears 1/4% eye drops -No open date was on Resident #17's container of atropine 1% eye drops -No open date was on Resident #19's container of Travatan Z 0.0045% eye drops -No open date was on Resident #25's container of artificial tears 1.4% eye drops -No open date was on Resident #12's container of artificial tears 1.4% eye drops -No open date was on Resident #6's container of Visine Original eye 		<p>found to be affected by the deficient practice. 2. All residents receiving Insulin and eye drops will have a date opened recorded on each item. All OTC medications will have labels applied. 3. The MAR has been updated to reflect ordering, open dates and expiration of all insulin and eye drops. Nursing staff was immediately in-serviced on medication labeling (3/3/2014 see audit #2). OTC medication will have label placed on container immediately when received. 4. Audit of medications will be done weekly for four weeks and then monthly for four months by Director of Nursing and/or designee. OTC medications will be monitored for labels weekly for four weeks and then monthly for four months by the Director of Nursing and/or designee. Audit of medications will be done weekly for four weeks and then monthly for four months by Director of Nursing and/or designee.</p>				

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	<p>drops</p> <p>-A vial of Novolog insulin for Resident #17 had an expiration date of 3-2-2014 (open date was 2-2-2014).</p> <p>-An OTC Cholesterol Reduction Complex bottle did not have a resident identifier on the medication bottle.</p> <p>-A container of Antifungal Powder with Miconazole Nitrate 2% was in a compartment in the treatment cart without a resident identifier on the container.</p> <p>-An OTC tube of triple antibiotic ointment was found in a compartment in the treatment cart without a resident identifier on the tube.</p> <p>An interview with QMA #5 on 3-3-2014 at 11:26 a.m., indicated Resident #17 was given the morning dose of Novolog insulin by the nurse from the vial with the expiration date of 3-2-2014.</p> <p>A review of the March 2014 MAR (Medication Administration Record) for Resident #17 on 3-3-2014 at 11:26 a.m., indicated Resident #17 had 4 units of Novolog administered on 3-3-2014 at 7:00 a.m.</p> <p>An interview with RN #6 on 3-3-2014</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155726		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
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	<p>at 11:26 a.m., indicated Resident #17 received 4 units of the Novolog insulin on 3-3-2014 at 7:00 a.m. from the Novolog insulin vial with the expiration date of 3-2-2014. RN #6 indicated she was supposed to check the expiration dates on the Novolog container prior to administering the insulin to the resident. RN #6 indicated the expiration date written on the Novolog was 3-2-2014.</p> <p>An interview with the DON (Director of Nursing) on 3-5-2014 at 8:50 a.m., indicated the OTC medications, ointments and powders should be labeled with the resident's name, physician and room number. The DON indicated the eye drops should have been labeled with the open date on each container and the Novolog insulin should not have been used after the expiration date.</p> <p>An "Expiration Dating and Document Requirements" instruction sheet dated 10-1-2003 was provided by RN #6 on 3-3-2014 at 11:26 a.m. and indicated "Novolog insulin - discard after 28 days."</p> <p>A policy "Expiration Dates and Compromised Medication" dated 5-9-2006 was provided by the DON</p>						

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	<p>on 3-5-2014 at 1:45 p.m., indicated "with some multi-dose containers it is important to complete the 'Date Opened' sticker. The expiration date is then dependent on this date...."</p> <p>A policy "Packaging and Labeling" dated 11-3-2006 and provided by the DON on 3-5-2014 at 1:45 p.m., indicated "over the counter medications must be identified with the following:</p> <p>A. Resident's full name B. Physician's name C. Expiration date D. Name of Drug E. Strength of drug...."</p> <p>3.1-25(j)(k)(l)</p>			