

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/10/2013
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NAME OF PROVIDER OR SUPPLIER CHARLES FORD MEMORIAL HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 920 S MAIN ST NEW HARMONY, IN 47631
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R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: October 9, 10, 2013</p> <p>Facility number: 001123 Provider number: 001123 Aim Number: N/A</p> <p>Survey team: Amy Wininger, RN, TC Denise Schwandner, RN Diana Perry, RN Anna Villain, RN Sylvia Martin, RN 10/09/13</p> <p>Census Bed Type Residential: 19 Total: 19</p> <p>Census payor type: Other: 19 Total: 19</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on October 14, 2013, by Jodi Meyer, RN</p>	R000000		
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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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R000154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure opened foods were covered in the freezer, failed to ensure a trash can was covered when not in use, failed to ensure food was not outdated, failed to ensure floors were free of debris. The facility also failed to ensure that food was protected from contamination. These observations were made during 2 of 2 observations. This had the potential to affect 19 residents who currently reside in the facility.</p> <p>Findings Include:</p> <p>During initial observation tour on 10/09/13 at 8:35 a.m. with the Executive Chef #1 present, the following observations were made:</p> <ol style="list-style-type: none"> 1. Chicken patties and chicken breasts were in opened bags in the freezer. 2. A large trash can in the food 	R000154	<p>All open food has been and shall be stored covered. Staff will be trained as to the importance of the requirement for storing open food covered. Storing open food covered shall be inspected every shift by the morning and evening cooking staff and monitored by the executive chef/dietary manager and/or designee on a daily basis. Said inspections shall be communicated via a daily check list monitoring tool, which shall be reviewed by the Home's dietician. Once opened, all food shall be labeled with the date of opening. Perishable foods that have been opened shall be used or discarded within five (5) days of opening. Staff will be trained as to the importance of the requirement for labeling all open food. Labeled open food shall be inspected every shift by the morning and evening cooking staff and monitored by the executive chef/dietary manager and/or designee on a daily basis. Said inspections shall be communicated via a daily check list monitoring tool, which shall be reviewed by the Home's dietician. Trash cans located in the kitchen have been and will remain</p>	10/30/2013

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	<p>preparation area was uncovered. The lid was on the floor beside the trash can.</p> <p>3. Food in the refrigerator was outdated. Three containers of cottage cheese were dated 10/04/13, one package of broccoli dated 09/03/13, one container of sour cream dated 09/28/13, three containers dated 10/04/13 and bean soup dated 09/30/13.</p> <p>4. The kitchen floor was observed to have food debris under a portable cart, in corners, and under cabinets.</p> <p>5. Sugar, flour, and rice were observed not to be stored in airtight containers.</p> <p>During a second observation tour on 10/10/13 at 9:45 a.m. the Executive Chef present, the following observations:</p> <p>6. Chicken patties and chicken breasts were in opened bags in the freezer.</p> <p>7. A large trash can in the food preparation area was uncovered. The lid was on the floor beside the trash can.</p>		<p>covered when not in use. Staff will be trained as to the importance of the requirement for keeping trash cans covered. Covered trash cans shall be inspected every shift by the morning and evening cooking staff and monitored by the executive chef/dietary manager and/or designee on a daily basis. Said inspections shall be communicated via a daily check list monitoring tool, which shall be reviewed by the Home's dietician. Floors have been cleared and shall be kept clear of debris. Staff will be trained as to the importance of the requirement for keeping floors clear of debris. Floor cleared of debris shall be inspected every shift by the morning and evening cooking staff and monitored by the executive chef/dietary manager and/or designee on a daily basis. Said inspections shall be communicated via a daily check list monitoring tool, which shall be reviewed by the Home's dietician. All open food has been and shall be protected from contamination. Staff will be trained as to the importance of the requirement for protecting food from contamination. Protecting food from contamination shall be inspected every shift by the morning and evening cooking staff and monitored by the executive chef/dietary manager and/or designee on a daily basis. Said</p>	

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	<p>8. Food in the refrigerator was outdated. Three containers of cottage cheese were dated 10/04/13, one package of broccoli dated 09/03/13, one container of sour cream dated 09/28/13, and bean soup dated 09/30/13.</p> <p>9. The kitchen floor was observed to have food debris under cabinets.</p> <p>During an interview on 10/10/13 at 9:45 a.m., the Executive Chef indicated that the food should be stored in bins.</p> <p>The policy and procedure for Cleaning and Sanitizing provided by the HFA (Health Facilities Administrator) on 10/10/13 at 2:00 p.m. indicated, "It is the responsibility of all dietetic service personnel...to clean...all areas of the kitchen..."</p> <p>The policy and procedure for Purchasing, Receiving and Storage provided by the HFA on 10/10/13 at 2:00 p.m. indicated, "...Procedures:...3...F. All food will be stored in areas protected from contamination by condensation, leakage, drainage, rodents or vermin..."</p> <p>During an interview on 10/10/13 at</p>		<p>inspections shall be communicated via adaily check list monitoring tool, which shall be reviewed by the Home'sdietician.This finding will bemonitored by the Home quality assurance program monthly for the first quarter,quarterly for the next three quarters and annually for the following year.</p>	

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	3:20 p.m. the HFA indicated that all outdated food should not have been in the refrigerator, that floors should be free of debris, and that trash should be covered.			

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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure the administration of medications were provided as ordered by the resident's physicians, in that, insulin was not administered as ordered by the physician (Resident #4) and a liquid antacid was not prepared for administration as ordered by the physician (Resident #6).</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure medications were not left unattended, in that, a medication for Resident #12 was left unattended on a dining table in reach of a confused resident (Resident #7), medications for Resident #16 were left unattended on the nurses desk (Resident #16), and a respiratory treatment was not supervised by the nurse (Resident #19).</p> <p>Findings include:</p>	R000241	(A)The facilityrespectfully submits clarification regarding the evidence related to thisfinding. All residents are observed for effects of medications. Documentation of any undesirable effects isrecorded in each resident's clinical record. Physicians are notified if undesirable effects occur. During the Medication Administration on10/09/13 at 11:50 AM, LPN #1 performed a blood glucometer test for Resident#4. LPN #1 indicated the result of thetest was 156 mm. LPN #1 exercised nursingjudgment in order to protect said resident, and determined the dose had thepotential to cause harm considering the resident's past history of "bottomingout". In accordance with the facility'spolicy and procedure, the resident was monitored by the nursing staff foradverse effects of said dose being withheld. There were none, which is consistent with the documentation on theResident's MAR. The Resident's blood glucometertest result at 4:00 PM on 10/09/13	10/30/2013			

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	<p>A. 1. During the initial tour on 10/09/13 at 9:30 a.m., the HFA (Health Facilities Administrator) indicated Resident #4 was interviewable.</p> <p>The clinical record of Resident #4 was reviewed on 10/09/13 at 10:00 a.m. The record indicated the diagnoses of Resident #4 included, but were not limited to, Diabetes.</p> <p>The most recent physician order recap dated 10/01/13 included but was not limited to, orders for: "...Accucheck [a blood glucose test] 3 [three] times daily... Novolog [fast-acting insulin] flexpen syringe SS [sliding scale]...: 0-150 =0u [units], 151-250=4u, 251& over=6 u..."</p> <p>A Service Plan dated 09/26/13 indicated, "...Resident requires staff assistance for blood glucometer testing and insulin administration..."</p> <p>During the Medication Administration Observation on 10/09/13 at 11:50 a.m., LPN #1 was observed to perform a blood glucometer test for Resident #4. LPN #1 indicated, at that time, the result of the test was 156 mm (millimeters)/Hg (mercury) and Resident #4 would not receive</p>		<p>was 144, which is an acceptable bloodglucose reading for said resident. Thefacility's policy and procedure requires physician notification when a residentexperiences adverse effects of amedication being withheld or when two consecutive doses (not days) of a vital medication are withheld. Saidresident's MAR containing blood glucose results and insulin administration arecommunicated to her physician on a monthly basis which is documented in herclinical record. The facilityrespectfully submits clarification regarding the evidence related to thisfinding. The Home maintains that during an interview on 10/10/13 at 10:00 AMwith the HFA, the HFA indicated that said resident's physician had beennotified the previous day of concerns related to this finding, which occurred at4:20 PM as is indicated in her clinical record. At 11:24 AM on 10/10/13 RN #1 indicated that said resident's physicianhad responded to notification of concerns related to this finding. LPN #1received written counseling related to this concern. LPN #1 and all nurses received additionaltraining related to medication administration and transcription on October 16,2013 via the Home's pharmacy consultant nurse. LPN#1 received additional training and medication pass observation onOctober 22,</p>				

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	<p>insulin coverage.</p> <p>The October 2013 MAR (Medication Administration Record) indicated the following:</p> <p>On 10/06/13 at 6:00 a.m., the blood glucometer result was 154 and no insulin was administered.</p> <p>On 10/07/13 at 6:00 a.m., the blood glucometer result was 151 and no insulin was administered.</p> <p>On 10/09/13 at 12:00 p.m., the blood glucometer result was 156 and no insulin was administered.</p> <p>The Nursing Notes from 10/01/13 through 10/09/13 at 1:30 p.m. lacked any documentation the physician had been notified of the insulin being held.</p> <p>During an interview on 10/09/13 at 2:53 p.m., LPN #1 indicated Resident #4 was a brittle diabetic and would bottom out if insulin was given according to the sliding scale as ordered by the physician.</p> <p>During an interview on 10/09/13 at 2:55 p.m., LPN #2 indicated she had been directed by the former WD (Wellness Director) not to administer insulin according to the sliding scale,</p>		<p>2013 via the Home's pharmacy consultant nurse. The Director of Nurses and/or designee will monitor the medication administration daily for compliance related to this finding, the pharmacy consultant nurse will monitor this finding during regular medication pass observation. Discrepancies will be reported to the administrator via the quality assurance report. This finding will be monitored by the Home quality assurance program monthly for the first quarter, quarterly for the next three quarters and annually for the following year. The medication cups that were difficult to read contributing to the measuring concern of liquid antacid for resident number #6 were immediately discarded. A new package of medication cups was opened, inspected and found to be clearly marked. The correct dose of two teaspoons (10cc's) was correctly measured and administered. LPN #1 received written counseling related to this concern. LPN #1 and all nurses received additional training related to medication administration and transcription on October 16, 2013 via the Home's pharmacy consultant nurse. LPN #1 received additional training and medication pass observation on October 22, 2013 via the Home's pharmacy consultant nurse. The Director of Nurses</p>		

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	<p>as a nursing measure, if the result was too close to 150 mm/Hg because Resident #4 did not tolerate the dose well and would experience a hypoglycemic reaction (low blood sugar). During an interview, at that time, LPN #1 and LPN #2 further indicated they had never notified the physician of Resident #4 the insulin had been withheld. LPN #2 then stated she had "...worked at the facility for over a year and have always done it that way..."</p> <p>During an interview on 10/10/13 at 10:00 a.m. the HFA indicated staff did not administer insulin as ordered and no documentation had been located to indicate the Physician had been notified of the medication having been withheld or related to Resident #4 having an adverse reaction when insulin was administered according to the physician's order.</p> <p>During an interview on 10/10/13 at 11:24 a.m., RN #1 indicated the physician had been notified that morning of the insulin being withheld and the resident reactions to current sliding scale orders and further indicated the physician had revised the sliding scale to "...160-250 mm/Hg give 4u...".</p>		<p>and/or designee will monitor the medication administration daily for compliance related to this finding, the pharmacy consultant nurse will monitor this finding during regular medication pass observation. Discrepancies will be reported to the administrator via the quality assurance report. This finding will be monitored by the Home quality assurance program monthly for the first quarter, quarterly for the next three quarters and annually for the following year. (B) The facility respectfully submits clarification regarding the evidence related to this finding. Medications were not left unattended by LPN #1, but were left in the possession of Resident #12 and Resident #16 both of whom are alert and oriented and fully capable of preventing their medications from being accidentally reached or taken by another resident. All residents who self-administer medication (including nebulizer treatments) will be reassessed for their capability to safely administer medications. Residents who do are not assessed to be capable of self-administration of medication will have their respiratory treatment administered by appropriate nursing staff in accordance with the facility's policy and procedure. Documentation of said assessments and subsequent physician order shall be</p>				

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	<p>A. 2. During the Medication Administration Observation on 10/09/13 at 10:55 a.m., LPN #1 was observed to pour 5 (five) cc (cubic centimeters) of a white liquid medication for Resident #6. During an interview, at that time, LPN #1 indicated the medication was an antacid that Resident #6 took routinely. LPN #1 further indicated, at that time, that 5 cc's were equal to 2 (two) teaspoons because the 5 cc marking was the second marking on the measuring cup (actual conversion is 10 (ten) cc equals 2 (two) teaspoons). At that time, the medication pass was stopped and during an interview LPN #1 indicated the markings on the measuring cups were difficult to read and she had not measured the medication correctly.</p> <p>The clinical record of Resident #6 was reviewed on 10/09/13 at 11:05 a.m.</p> <p>The most recent Physician's Order Recap dated 10/01/13 included, but was not limited to, an order for, "...MI Acid [an antacid] 2 [two] tsp [teaspoon] po [by mouth] before meals and at hs [hour of sleep] for heartburn...".</p>		<p>maintained in each resident's medical record. LPN #1 received written counseling related to this concern. LPN #1 and all nurses received additional training related to medication administration and transcription on October 16, 2013 via the Home's pharmacy consultant nurse. LPN#1 received additional training and medication pass observation on October 22, 2013 via the Home's pharmacy consultant nurse. The Director of Nurses and/or designee will monitor the medication administration daily for compliance related to this finding, the pharmacy consultant nurse will monitor this finding during regular medication pass observation. Discrepancies will be reported to the administrator via the quality assurance report. This finding will be monitored by the Home quality assurance program monthly for the first quarter, quarterly for the next three quarters and annually for the following year.</p>				

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	<p>The Policy and Procedure for Medication Administration-General guidelines provided by the HFA on 10/10/13 at 10:00 a.m. indicated, "...B. Administration: ...2) Medications are administered in accordance with written orders of the attending physician. 3) If a dose seems excessive...the nurse contacts the prescriber for clarification...If a dose of regular scheduled medication is withheld...if (two consecutive days) of a vital medication are withheld or refused, the physician is notified..."</p> <p>B.</p> <p>1.</p> <p>During the initial tour on 10/09/13 at 9:30 a.m. LPN #1 identified Resident #12 as interviewable and Resident #7 as not interviewable related to recent confusion.</p> <p>During the Medication Administration Observation on 10/09/13 at 11:30 a.m., LPN #1 was observed to prepare Hydralazine (a medication for high blood pressure) 50 mg (milligram) for Resident #12. LPN #1 was then observed to deliver the medication to the dining table of Resident #12. Resident #7 was observed, at that time, to be sitting next to Resident #12 at the dining</p>						

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	<p>table. On 10/09/13 at 11:31 a.m., LPN #1 was observed to place the medication on the dining table and leave the dining room. LPN #1 was observed to return to the dining room on 10/09/13 at 11:35 a.m. and place a cup in front of Resident #12. (The unattended medication was observed to be within the reach of a confused resident for 4 [four] minutes).</p> <p>2. During the Medication Administration Observation on 10/09/13 at 11:37 a.m., LPN #1 was observed to prepare the following medications for Resident #16 and place on the nurses desk.</p> <p>Pepcid (a medication for heartburn) 20 mg (milligrams), Metoprolol (a medication for high blood pressure) 50 mg, Celexa (an anti-depressant) 20 mg, Lisinopril (a medication for high blood pressure) 10 mg, Vitamin C (a supplement) 500 mg, and Librium (a medication for anxiety) 5 mg</p> <p>LPN #1 was then observed to exit the nurse's office on 10/09/13 at 11:39 a.m. and leave the office door open to the hallway. LPN #1 was observed on 10/09/13 at 11:41 a.m. to return to</p>						

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	<p>the office with a cup. (The medication was observed to be unsupervised for 2 minutes)</p> <p>During an interview 10/10/13 at 3:00 p.m., the HFA (Health Facilities Administrator) indicated there was no specific policy related to leaving medications unattended, but medications should be supervised or secure at all times.</p> <p>3. The clinical record of Resident #19 was reviewed on 10/09/13 at 10:30 a.m. The record indicated Resident #19 did not self-administer medications.</p> <p>During the Medication Administration Observation on 10/09/13 at 12:35 p.m., LPN #1 was indicated she was going to administer a breathing treatment to Resident #19. On 10/09/13 at 12:36 p.m. LPN #1 was observed to to enter the room of Resident #19, prepare the respiratory treatment and exit the room. During an interview, at that time, LPN #1 indicated Resident #19 was used to taking care of the breathing treatments herself and then indicated she would sometimes return and take the breathing treatment off for Resident #19.</p>						

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	<p>On 10/10/13 at 12:45 p.m., Resident #19 was observed to remove the respiratory treatment and turn the nebulizer off.</p> <p>During an interview on 10/09/13 at 3:50 p.m., LPN #2 indicated resident's should be constantly monitored during respiratory treatments.</p> <p>The Pharmacy Specific medication administration procedures provided by the HFA on 10/10/13 at 10:00 a.m. indicated, "Procedures:...J. Start the therapy:...K. Encourage a breathing pattern ...L. assess the resident and contact the physician if the following occur:..."</p> <p>The Policy and Procedure for Medication Administration-General Guidelines provided by the HFA on 10/10/13 at 10:00 a.m. indicated, "...B. Administration:...3) The resident is always observed after administration to ensure that the dose was completely ingested..."</p>						

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R000242	<p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician was notified of medication adverse reactions and being withheld, in that, insulin was withheld and the physician was not notified. (Resident #4)</p> <p>Findings include:</p> <p>1. During the initial tour on 10/09/13 at 9:30 a.m., the HFA (Health Facilities Administrator) indicated Resident #4 was interviewable.</p> <p>The clinical record of Resident #4 was reviewed on 10/09/13 at 10:00 a.m. The record indicated the diagnoses of Resident #4 included, but were not limited to, Diabetes.</p> <p>The most recent physician order recap dated 10/01/13 included but was not limited to, orders for: "...Accucheck [a blood glucose test] 3</p>	R000242	<p>The facility respectfully submits clarification regarding the evidence related to this finding. All residents are observed for effects of medications. Documentation of any undesirable effects is recorded in each resident's clinical record. Physicians are notified if undesirable effects occur. During the Medication Administration on 10/09/13 at 11:50 AM, LPN #1 performed a blood glucometer test for Resident #4. LPN #1 indicated the result of the test was 156 mm. LPN #1 exercised nursing judgment in order to protect said resident, and determined the dose had the potential to cause harm considering the resident's past history of "bottoming out". In accordance with the facility's policy and procedure, the resident was monitored by the nursing staff for adverse effects of said dose being withheld. There were none, which is consistent with the documentation on the Resident's MAR. The Resident's blood glucometer test result at 4:00 PM on 10/09/13 was 144, which is an acceptable blood</p>	10/30/2013			

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	<p>[three] times daily... Novolog [fast-acting insulin] flexpen syringe SS [sliding scale]...: 0-150 =0u [units], 151-250=4u, 251& over=6 u..."</p> <p>A Service Plan dated 09/26/13 indicated, "...Resident requires staff assistance for blood glucometer testing and insulin administration..."</p> <p>During the Medication Administration Observation on 10/09/13 at 11:50 a.m., LPN #1 was observed to perform a blood glucometer test for Resident #4. LPN #1 indicated, at that time, the result of the test was 156 mm (millimeters)/Hg (mercury) and Resident #4 would not receive insulin coverage.</p> <p>The October 2013 MAR (Medication Administration Record) indicated the following:</p> <p>On 10/06/13 at 6:00 a.m., the blood glucometer result was 154 and no insulin was administered.</p> <p>On 10/07/13 at 6:00 a.m., the blood glucometer result was 151 and no insulin was administered.</p> <p>On 10/09/13 at 12:00 p.m., the blood glucometer result was 156 and no insulin was administered.</p>		<p>glucose reading for said resident. The facility's policy and procedure requires physician notification when a resident experiences adverse effects of a medication being withheld or when two consecutive doses (not days) of a vital medication are withheld. Said resident's MAR containing blood glucose results and insulin administration are communicated to her physician on a monthly basis which is documented in her clinical record. The facility respectfully submits clarification regarding the evidence related to this finding. The Home maintains that during an interview on 10/10/13 at 10:00 AM with the HFA, the HFA indicated that said resident's physician had been notified the previous day of concerns related to this finding, which occurred at 4:20 PM as is indicated in her clinical record. At 11:24 AM on 10/10/13 RN #1 indicated that said resident's physician had responded to notification of concerns related to this finding. LPN #1 received written counseling related to this concern. LPN #1 and all nurses received additional training related to medication administration and transcription on October 16, 2013 via the Home's pharmacy consultant nurse. LPN #1 received additional training and medication pass observation on October 22, 2013 via the Home's pharmacy consultant nurse. The Director</p>				

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	<p>The Nursing Notes from 10/01/13 through 10/09/13 at 1:30 p.m. lacked any documentation the physician had been notified of the insulin being held.</p> <p>During an interview on 10/09/13 at 2:53 p.m., LPN #1 indicated Resident #4 was a brittle diabetic and would bottom out if insulin was given according to the sliding scale, as ordered by the physician.</p> <p>During an interview on 10/09/13 at 2:55 p.m., LPN #2 indicated she had been directed by the former WD (Wellness Director) not to administer insulin according to the sliding scale, as a nursing measure, if the result was too close to 150 mm/Hg because Resident #4 did not tolerate the dose well and would experience a hypoglycemic reaction (low blood sugar). During an interview, at that time, LPN #1 and LPN #2 further indicated they had never notified the physician of Resident #4 the insulin had been withheld. LPN #2 then stated she had "...worked at the facility for over a year and have always done it that way..."</p> <p>During an interview on 10/10/13 at 10:00 a.m. the HFA indicated staff did not administer insulin as ordered and</p>		<p>ofNurses and/or designee will monitor the medication administration daily for compliance related to this finding, the pharmacy consultant nurse will monitor this finding during regular medication pass observation. Discrepancies will be reported to the administrator via the quality assurance report. This finding will be monitored by the Home quality assurance program monthly for the first quarter, quarterly for the next three quarters and annually for the following year.</p>				

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	<p>no documentation had been located to indicate the Physician had been notified of the medication having been withheld or related to Resident #4 having an adverse reaction when insulin was administered according to the Physician's order.</p> <p>During an interview on 10/10/13 at 11:24 a.m., RN #1 indicated the physician had been notified that morning of the insulin being withheld and the resident reactions to current sliding scale orders and indicated the physician had changed the sliding scale.</p> <p>The Policy and Procedure for Medication Administration-General guidelines provided by the HFA on 10/10/13 at 10:00 a.m. indicated, "...B. Administration: ...2) Medications are administered in accordance with written orders of the attending physician. 3) If a dose seems excessive...the nurse contacts the prescriber for clarification...If a dose of regular scheduled medication is withheld...If (two consecutive days) of a vital medication are withheld or refused, the physician is notified..."</p>						

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R000356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the emergency information file contained information for 1 of 7 residents reviewed in a sample of 7 for having emergency file information. (Resident #11)</p> <p>Findings include:</p> <p>The clinical record of Resident #11 was reviewed on 10/09/13 at 11:00 a.m. The record indicated Resident #11 was admitted on 10/04/13 with diagnoses including, but not limited to, HTN (high blood pressure) The</p>	R000356	The facility acknowledges that it did maintain appropriate emergency file information on all residents on October 9, 2013 with the exception of the one recent admission. Emergency information for resident # 11 was immediately added to the Emergency File upon discovery of this oversight. All nursing staff received appropriate training related to Emergency File information. Emergency file information is indicated on the nursing admission checklist. The Director of Nurses and/or designee will monitor the admission checklist for compliance related to this finding, discrepancies will be reported to	10/10/2013			

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	<p>emergency information file lacked any documentation related to Resident #11.</p> <p>Resident #11 was observed on 10/09/13 at 3:45 p.m., sitting in a chair watching television.</p> <p>During an interview on 10/09/13 at 2:30 p.m., LPN #1 indicated the emergency information contained no information for Resident #11.</p> <p>The policy and procedure for Emergency Information provided by the HFA (Health Facilities Administrator) on 10/09/13 at 10:00 a.m., indicated emergency information should be completed upon admission and the Wellness nurse was responsible for coordination of this information.</p> <p>During an interview on 10/10/13 at 4:00 p.m., the HFA indicated the emergency file information should have been done for on admission and it had been missed.</p>		<p>the administrator via the quality assurance report. This finding will be monitored by the Home quality assurance program monthly for the first quarter, quarterly for the next three quarters and annually for the following year.</p>				

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R000414	<p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) 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>Based on observation, interview, and record review, the facility failed to ensure proper hand washing and/or hand hygiene was performed for 3 of 6 residents observed during the medication pass, in that, hand washing and/or hand hygiene was not performed between resident contacts and/or after the removal of gloves. (Resident #12, Resident #16, Resident #17)</p> <p>Findings include:</p> <p>During the medication administration observation on 10/09/13 at 11:30 a.m., LPN #1 was observed to prepare and administer medication to Resident #12. LPN #1 was observed, at that time, to not perform hand washing and/or hand hygiene. LPN #1 was then observed to prepare and administer medication to Resident #16. LPN #1 was observed, at that time, to not perform hand washing and/or hand hygiene.</p> <p>During the medication administration observation on 10/09/13 at 11:50</p>	R000414	<p>The facility respectfully submits clarification regarding the evidence related to this citing. The facility (as evidenced by its policy and procedure related to medication administration submitted to surveyors on 10/09/13) requires "hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medication," and to "cleanse hands before handling medication and before contact with resident." The facility maintains that the system for dispensing and administering oral medications is such that contact by the person administering it is not required, nor is direct contact with the resident. The surveyor's evidence does not indicate that the nurse administering medication on 10/09/13 had direct contact with medications being administered, nor with the resident. The staff member (LPN #1) received written counseling regarding the surveyor's evidence. LPN #1 reported she had alcohol gel in the pocket of her lab jacket and did use alcohol gel before dispensing medicine for each resident. LPN #1 reported she may not always have been in</p>	10/16/2013			

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	<p>a.m., LPN #1 was observed to apply gloves and perform a blood glucometer test. LPN #1 was then observed to remove the gloves and not perform hand washing and/or hand hygiene. LPN #1 was then observed to prepare and administer medication to Resident #17.</p> <p>The policy and procedure for Specific Medication Administration Procedures Provided by the HFA (Health Facilities Administrator) on 10/10/13 at 10:00 a.m. indicated, "Procedures:...H. Cleanse hands before handling medication and before contact with resident....During an interview, at that time, the HFA indicated hand washing and/or hand hygiene should be performed between resident contacts and between glove changes.</p>		<p>the surveyor's direct line of vision during medication administration. The staff received educated related to hand hygiene on March 12, 2013 as part of universal precautions training, again on September 10, 2013 as part of infection control training and again on October 16, 2013 as part of medication administration training. The facility maintains that it does require staff to maintain proper hand hygiene as indicated by accepted professional practice. This concern will be monitored by the pharmacy consultant nurse during monthly random medication pass inspections. Concerns will be communicated via the inspection report. This concern will be monitored monthly by the quality assurance program monthly for the first quarter, then quarterly for the remaining three quarters, then annually the following year.</p>		