

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155721	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
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NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00143249.</p> <p>Complaint IN00143249 substantiated. Deficiencies related to the allegations are cited at F329.</p> <p>Survey dates: April 10, 11, 12, 14, 15 and 16, 2014</p> <p>Facility number: 000383 Provider number: 155721 AIM number: 100289610</p> <p>Survey team: Karina Gates, Generalist TC Courtney Mujic, RN (April 10, 11, 14, 15 and 16, 2014) Beth Walsh, RN (April 10, 11, 14 and 15, 2014) Tom Stauss, RN (April 10, 11, 14, 15 and 16, 2014)</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census payor type: Medicare: 4</p>	F000000	<p>ID Prefix Tag: SurveyEvent ID FVWC11 Survey Date: April 16, 2014</p> <p>Please consider this Plan of Correction as the facility credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law.</p> <p>Lawrence Manor Healthcare Center is respectfully requesting a desk review.</p> <p>If there are any further questions or concerns, please feel free to contact me at 317-898-1515.</p> <p>Respectfully,</p> <p>Devon Brewer, HFA, MHA Administrator</p>	
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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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F000156 SS=C	<p>Medicaid: 30 Other: 13 Total: 47</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 25, 2014 by Cheryl Fielden, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the</p>				

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	<p>State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman</p>			

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	<p>program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to provide residents Medicare Advance Beneficiary Notices of Noncoverage (ABN) for 3 of 3 residents reviewed for ABN notices. (Resident #17, #21 and #54)</p> <p>Findings include:</p> <p>The ABN notices for Residents #17, #21 and #54 were requested from the Administrator on 4/14/14 at 2:00 p.m.</p> <p>During an interview with the Administrator on 4/14/14 at 2:30 p.m. she indicated, "We don't have copies of any of these cut letters (ABN notices.)"</p>	F000156	<p>ID Prefix Tag: F156- C</p> <p>Cycle Date: November 20, 2013</p> <p>Survey Date: November 20, 2013</p> <p>Notice of Rights, Rules, Services, Charges</p> <p>It is the policy of this facility that a Medicare AdvanceBeneficiary Notices of Noncoverage (ABN) must be given when Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare Program standards or because it is considered custodial care. The beneficiary and the health care provider must each retain one</p>	05/16/2014

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	<p>Regarding whether the 3 residents should have been provided notices, she indicated, "Yes, I think they should. Therapy gets them together and social services gets them signed. They were cut back in November (2013), and it doesn't look like we did them."</p> <p>On 4/14/14 at 2:45 p.m., the Social Services Director provided the first and last covered days of Medicare services for Residents #17, #21 and #54. The first covered day for Resident #17 was 10/25/13, and the last covered day was 11/13/13. The first covered day for Resident #21 was 9/25/13, and the last covered day was 11/10/13. The first covered day for Resident #54 was 1/29/14, and the last covered day was 2/28/14.</p> <p>On 4/15/14 at 10:45 a.m., the Administrator provided a copy of the ABN policy. It indicated, "An ABN must be given when Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare Program standards or because it is considered custodial care....The beneficiary and the health care provider must each retain one copy of the signed ABN."</p>		<p>copy of the sign ABN.</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice?</p> <ul style="list-style-type: none"> · Facility will provide the Medicare Advance Beneficiary Notices of Noncoverage at least 48 hours prior to Noncoverage date from this date forward · Facility will keep a copy of the notice and supply the resident and/or responsible party with copy of ABN from this date forward · R#17 was given information re: Medicare Advance Beneficiary Notices of Noncoverage (ABN). R#21 and R#54 were discharged prior to survey <p>How will the facility identify residents having the potential to be affected by the same deficient practice?</p> <ul style="list-style-type: none"> · All residents who receive Medicare skilled services could have the potential to be affected by this finding <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Facility will designate the Social Service Director to be responsible for informing resident and/or responsible party of ABN and having the form signed · Facility will designate the Social Service Director to be 				

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F000164 SS=D	<p>3.1-4(f)(3)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p>		<p>responsible for appropriate documentation of informing resident and/or responsible party of ABN</p> <ul style="list-style-type: none"> ·Facility will implement a Medicare meeting to discuss those receiving services under Medicare <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> ·Social Service Director will ensure that a copy of the form is in the financial file immediately following receiving the signature ·B.O.M will audit 1 Medicare file per week times 3 months then 2 Medicare files monthly times 3 months. These audits will continue until 100 % compliance is achieved for one full quarter ·Results will be presented to Quality Assurance Committee monthly <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> ·May 16, 2014 		

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	<p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy for 1 of 1 residents reviewed for privacy. (Resident #29)</p> <p>Resident #29's record was reviewed on 4/11/14 at 10:02 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II, peripheral vascular disease, osteoporosis, chronic pain, senile dementia, Alzheimer's with depression. An MDS (minimum data set) record dated 1/21/14 indicated a BIMS (brief interview for mental status) score of 15 for Resident #29.</p> <p>On 4/11/14 at 10:44 a.m., during an observation, Resident #29 was observed</p>	F000164	<p>ID Prefix Tag: F164- D Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Personal Privacy/Confidentiality of Records</p> <p>It is the policy of this facility ...</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice? ·R#29 agrees her preference is to have the doors shut when receiving showers</p> <p>How will the facility identify residents having the potential</p>	05/16/2014

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	<p>in the Unit 2 shower room with CNA #1. Resident #29 was receiving shower care. The shower room did not have a door, but only a curtain separating a hallway from the shower room. CNA #1 left the room at 10:45 a.m., to assist Resident #66 in the hallway. The shower room curtain (that was being used as a door) was partially open. Resident #29 was observed, from the hallway, seated in the shower room with her pants below her knees and her genital area exposed.</p> <p>On 4/11/14 at 11:03 a.m., during an interview, Resident #29 indicated she preferred to have the shower door closed while she was receiving a shower for privacy purposes. On 4/11/14 at 12:59 p.m., CNA #5 indicated he gave Resident #29 a shower on 4/11/14 before lunch. He indicated the resident prefers to have the shower door open because "she says it gets too hot in there." The CNA indicated the door to the Unit 2 shower room was able to be closed while a resident was receiving a shower in the unit 2 shower room.</p> <p>On 4/14/14 at 1:35 p.m., during an interview with the DON and Administrator, they indicated it is acceptable according to facility policy for staff who are providing showers to residents to use either the shower room</p>		<p>to be affected by the same deficientpractice? ·All residents have the potential to be affected by this finding</p> <p>What measure will be put into place or systematic changesmade to ensure that the deficient practice will not recur? ·A shower audit will be completed to ensure residents privacy is being maintained. Stating preference of door being shut, curtain being drawn or both privacy measures in place. ·Preference of care will be added to Nursing Care Instruction Sheet</p> <p>How will facility monitor its corrective actions? ·Admin or designee will make daily rounds during common showering hours to ensure requested preferences are being followed daily x 2 weeks then monthly there after until 100% compliance is achieved for one full Quarter</p> <p>·Results will be presented to Quality Assurance Committee monthly</p> <p>Date the deficiency will be corrected? ·May 16, 2014</p>	

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F000278 SS=D	<p>curtain divider or the shower room door for privacy.</p> <p>A facility policy titled "Resident Privacy" was received from the Administrator on 4/14/14 at 11:27 a.m. It indicated "...Doors, curtains, and privacy curtains shall be closed during Resident care activities to provide full visual privacy..."</p> <p>On 4/14/14 at 11:31 a.m., during an interview, the Administrator indicated a resident who could be seen from a hallway while in the shower room had not received "full visual privacy."</p> <p>3.1-3(o) 3.1-8(a) 3.1-22(c)(3) 3.1-3(p)(4)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that</p>			

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	<p>the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview and record review, the facility failed to ensure accuracy of the MDS (minimum data set) assessment for 1 of 15 residents reviewed for MDS assessments. (Resident #16)</p> <p>Findings include:</p> <p>The clinical record for Resident #16 was reviewed on 4/15/14 at 11:00 a.m.</p> <p>The diagnoses for Resident #16 included, but were not limited to: pneumonia and hypertension.</p> <p>An observation of Resident #16 was made on 4/10/14 at 1:14 p.m. He had 1 noticeable tooth on top, in the front of his</p>	F000278	<p>ID Prefix Tag: F278- D</p> <p>Cycle Date: November 20, 2013</p> <p>Survey Date: November 20, 2013</p> <p>Assessment Accuracy/Coordination/Certified</p> <p>It is the policy of this facility ...</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice? ·R#16 MDS was reviewed and updated to reflect current status</p> <p>How will the facility identify residents having the potential</p>	05/16/2014

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	<p>mouth. The teeth next to this tooth were broken and some missing.</p> <p>The oral/dental status section of Resident #16's 2/11/14 significant change MDS assessment indicated he did not have any obvious or likely cavities or broken teeth.</p> <p>The 2/27/14 Dental Exam Summary for Resident #16 indicated, "Tooth Notes: 6-8 bridge is lost due to gross decay and #9 slight mobility, severe enamel wear on lower..."</p> <p>An interview was conducted with the MDS Coordinator on 4/15/14 at 11:25 a.m., regarding how a resident's dental status was assessed for the MDS assessment. She indicated, "I tell them what I'm doing, look in their mouth, ask them if they've had any problems with chewing, pain." Regarding whether this was how she assessed Resident #16 for his 2/11/14 significant change MDS assessment, she indicated, "Yes. I do them the same with everyone. We always refer to the dentist right away if I find problems."</p> <p>An observation of Resident #16's oral cavity was made with the MDS Coordinator on 4/15/14 at 11:30 a.m. She looked in Resident #16's mouth. Resident #16 pointed to his teeth on the</p>		<p>to be affected by the same deficientpractice?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by this finding <p>What measure will be put into place or systematic changesmade to ensure that the deficient practice will not recur?</p> <ul style="list-style-type: none"> ·An audit sheet was developed to initially review all 47 MDS records for accuracy ·Any corrections required were reviewed and completed <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> ·Audit sheet will be used weekly during care plan meetings to ensure accuracy within MDS ·DON or designee will review audit sheets to assure information is correct and reflects residents current status during care plans weekly.This process will be monitored by reviewing one MDS weekly times 4 weeks then 2 per month times 3 months.This will continue until 100% compliance has been achieved for one full quarter ·Results will be presented to Quality Assurance Committee monthly <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> ·May 16, 2014 	

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F000279 SS=D	<p>upper left and stated, "These ones are fine." Then he pointed to his upper right teeth and stated, "But over here..."</p> <p>During an interview with the MDS Coordinator on 4/15/14 at 11:32 a.m. regarding her observation of Resident #16's teeth, she indicated, "I saw the broken teeth. I think I didn't input the right information for the 2/11/14 sig (significant) change. I'm going to do a correction on the MDS."</p> <p>3.1-31(d) 3.1-31(c)(9)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a skin impairment care plan for a resident who had skin damage on their coccyx and left heel and a care plan for anti-psychotic/anti-anxiety use. This affected 1 of 15 residents reviewed for care plans. (Resident #59)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident #59 was reviewed 4/15/14 at 10:45 a.m. The diagnoses for Resident #59 included, but were not limited to, brain cancer, hepatitis C, history of cerebral vascular accident, and seizure disorder. Resident #59 was admitted on 11/4/13.</p> <p>A document titled, Non-Decubitus Skin Condition, dated 12/8/13, indicated Resident #59 had moisture related skin damage to their coccyx area. Another document titled, Non-Decubitus Skin Condition, dated 12/27/13, indicated the left heel of Resident #59 had a blister that opened. A document titled, Wound Documentation, dated 1/10/14, indicated Resident #59 had an "unstageable"</p>	F000279	<p>ID Prefix Tag: F279- D Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Develop Comprehensive Care Plans</p> <p>It is the policy of this facility to develop a comprehensive care plan for each resident that includes objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice? ·R#59 was discharged prior to survey ·Appropriate care plans will be implemented for every identified as having been affected by the alleged deficient practice</p> <p>How will the facility identify residents having the potential to be affected by the same deficient practice? ·All residents have the potential to be affected by this finding</p>	05/16/2014

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	<p>wound that measured 7 cm (centimeters) by 6 cm on their left heel.</p> <p>1b. The Admission Physician's Orders for Resident #59 indicated orders for haldol (anti-psychotic medication) 2 mg (milligrams) sublingual (under tongue) every 4 hours and risperdal (anti-psychotic medication) 3 mg every morning. A telephone Physician's Order, dated 11/7/14, indicated an order for lorazepam intensol (anti-anxiety medication) 1 mg sublingual every hour as needed.</p> <p>The 11/10/13 Admission MDS (Minimum Data Set) Assessment, for Resident #59, indicated a need for a care plan for psychotropic drug use.</p> <p>The care plans were reviewed for Resident #59. Care plans for skin impairment, use of anti-psychotic medication, and use of anti-anxiety medication were not located in the clinical record.</p> <p>During an interview with the Director of Nursing (DoN), on 4/15/14 at 2:15 p.m., she indicated she was unable to locate care plans for skin impairment, use of anti-psychotic medication, and use of anti-anxiety medication. She further indicated the Resident should have had</p>		<p>·Residents at risk for skin breakdown and have impaired skin could be affected by this finding</p> <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p> <p>·Social Service Director will check MD orders when completing MDS' and will ensure psychotropic medication care plan is in place if needed with each assessment</p> <p>·Care plans will be reviewed by the IDT during care plan meetings and care plans will be added PRN</p> <p>·Social Service Director will be communicated all changes concerning psychotropic medication orders and will update care plans as needed</p> <p>How will facility monitor its corrective actions?</p> <p>·Facility consultant will review MD orders and cross reference for appropriate care plans regarding anti-psychotic medications over the next 3 months</p> <p>·Audit sheet will be used weekly during care plan meetings to ensure accuracy within care plans</p> <p>·These audit sheets will be reviewed by SSC weekly times 4 weeks then monthly times 6 months</p> <p>·Results of Audits will be presented to Quality Assurance Committee monthly.</p>	

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F000280 SS=D	<p>all 3 care plans as part of their clinical record.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to update a care plan regarding medication administration techniques for 1 of 17 residents reviewed for care plans. (Resident #66)</p>	F000280	<p>The Quality Assurance committee will oversee compliance</p> <p>Date the deficiency will be corrected? May 16, 2014</p> <p>ID Prefix Tag: F280- D Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Right To Participate Planning Care</p> <p>It is the policy of this facility to develop a comprehensive care plan</p>	05/16/2014	

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	<p>Resident #66's record was reviewed on 4/14/14 at 9:57 a.m. The resident's diagnoses included, but were not limited to, psychosis, schizophrenia, anxiety, extra pyrimidal symptoms (EPS), agitation. The resident's medications included, but were not limited to, Risperdal Consta 25 mg once intramuscularly every two weeks, trazodone 50 mg at bedtime, clonazepam 2 mg daily at bedtime, olanzapine 10 mg twice daily, clonazepam 1mg two times daily, cogentin 0.5mg two times daily, lorazepam 1mg every 4 hours orally daily or lorazepam 1mg every 4 hours intramuscularly if refuses oral administration.</p> <p>On 4/14/14 at 10:29 a.m., during an observation, Resident #66 was observed yelling at staff who were trying to redirect him. He was observed attempting to wheel himself (in his wheelchair) into a facility staff office.</p> <p>A psychiatric evaluation, dated 3/28/14, was reviewed in the clinical record. It indicated Resident #66 "...continued to have..." auditory and visual hallucinations and the evaluation also indicated "...medication compliance is still an issue..."</p> <p>Care plans for Resident #66, with a</p>		<p>for each resident that includes objectives and timetables to meet aresident's medical, nursing, mental, and psychosocial needs that are identifiedin the comprehensive assessment.</p> <p>How will correctiveaction be accomplished for those residents who are affected by this allegeddeficient practice?</p> <ul style="list-style-type: none"> ·R#66 care plan was updated to reflect currentstatus ·Appropriate care plans will be implemented for every resident identified as having been affected by this deficient practice <p>How will the facilityidentify residents having the potential to be affected by the same deficientpractice?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by this finding. <p>What measure will be put into place or systematic changesmade to ensure that the deficient practice will not recur?</p> <ul style="list-style-type: none"> ·Upon completion of Comprehensive MDS Assessment for every resident in the facility, Social Service Director will update and individualize care plans to meet the residents needs ·During behavior management meetings, behavior care plans will be reviewed and updated as necessary <p>How will facility monitor its</p>	

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	<p>review date of 4/2/14, were reviewed. No care area relating to medication refusals were observed in care plans.</p> <p>A physician's order, dated 3/26/14, indicated the following: "...may disguise medications in food or fluids PRN..."</p> <p>On 4/14/14 at 11:37 a.m., the DON indicated the physician's order, dated 3/26/14, which indicated "...may disguise medications in food or fluids PRN (as needed)...", should have been added to Resident #66's care plan.</p> <p>On 4/16/14 at 12:22 p.m., the DON indicated the facility added interventions to Resident #66's care plan on 4/14/14, related to disguising medications, due to Resident #66's history of refusing medication and treatment. She indicated the facility nursing staff occasionally disguises medication in Resident #66's food in order to keep "a certain level in his system" regarding the medications prescribed for Resident #66. The DON indicated the facility should have updated Resident #66's care plan to reflect disguising medication in food.</p> <p>3.1-35(d)(2)(B)</p>		<p>corrective actions?</p> <ul style="list-style-type: none"> ·Audit sheet will be used weekly during care plan meetings to ensure accuracy within behavior management care plans ·DON or designee will monitor ongoing compliance x 4 weeks then monthly there after x 3 months .These audits will continue until 100% compliance has been achieved for one full quarter ·Results will be presented to the Quality Assurance Committee monthly ·The Quality Assurance committee will oversee compliance <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> ·May 16, 2014 	

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident with severely impaired cognition had their POA's (Power of Attorney) assistance with determining their code status. This affected 1 of 1 residents reviewed for code status (Resident #20).</p> <p>Findings include:</p> <p>The clinical record for Resident #20 was reviewed 4/14/14 at 1:45 p.m. The diagnoses for Resident #20 included, but were not limited to, vascular dementia, insomnia, spasticity, chronic pain, and anxiety.</p> <p>The 12/10/13 Quarterly MDS (Minimum Data Set) Assessment indicated Resident #20 had a BIMS (Brief Interview of Mental Status) of 6, which was indicative</p>	F000309	<p>ID Prefix Tag: F309- D Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Provide Care/ Services For Highest Well Being</p> <p>It is the policy of this facility to...CPR POLICY</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice? ·Social Service Director will speak with Resident#20 POA and will document conversation</p> <p>How will the facility identify residents having the potential to be affected by the same deficient practice? ·All residents have the potential to be affected by this finding.</p>	05/16/2014

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	<p>of severely impaired cognition.</p> <p>Resident #20's Code Classification Form was signed by Resident #20 on 12/3/13.</p> <p>A document from a medical doctor's appointment, titled Short Term Resident Referral, was dated 2/26/13. The document indicated the following, "...New Orders for Health Care Center....2. Please address code status again-he is not capable of making decisions...."</p> <p>During an interview with the Social Services Director (SSD), on 4/15/14 at 9:22 a.m., she indicated when a resident had a BIMS of 6, it indicated the resident had severely impaired cognition and would be unable to make decisions for themselves. The SSD also indicated she contacted the Resident's POA and the POA indicated to let the Resident determine their own code status, because he had no way of signing anything. The SSD also indicated she let the POA know about the new order above and the POA indicated he will sign something the next time he comes into the facility. The SSD further indicated she had no documentation of when either of these events occurred.</p> <p>On 4/15/14, at 9:44 a.m., during a phone</p>		<p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p> <ul style="list-style-type: none"> ·Social Service Director will review code status forms and date signed and by whom ·Social Service Director will document any code status conversations within each residents social service progress note to ensure up to date and accurate information <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> ·Audit sheet will be used weekly during care plan meetings to ensure accuracy within code status care plans ·DON or designee will review audit sheets weekly times 4 weeks then monthly until 100% compliance has been achieved for one full quarter ·Results will be presented to Quality Assurance Committee monthly ·The Quality Assurance committee will oversee compliance <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> ·May 16, 2014 	

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F000323 SS=E	<p>interview with Resident #20's POA, he indicated he did not recall a discussion regarding the code status of Resident #20 and letting the Resident make his own decisions. The POA further indicated he was at the facility the previous week and no one addressed the code status for Resident #20 with him.</p> <p>A review of a care plan for, "impaired cognition...and impaired decision making as evidenced by a BIMS score of 6," dated 9/24/13, indicated an intervention of, "the resident needs assistance with all decision making."</p> <p>3.1-37(a)</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</p>				

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	<p>assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to adequately supervise a cognitively impaired resident resulting in an incident involving the spraying of a fire extinguisher and a resident to resident altercation for 1 of 4 residents reviewed for accidents and to ensure chemicals were kept locked up in the laundry room which had the potential to affect 7 of 38 ambulatory residents of 47 who reside in the facility. (Resident #'s 66, 20, 14, 16, 44, 32, 37 and 34)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #66 was reviewed on 4/16/14 at 10:30 a.m.</p> <p>The diagnoses for Resident #66 included, but were not limited to: traumatic brain injury.</p> <p>Observations of Resident #66 yelling out loudly were made on the following dates and times: 4/11/14 at 10:00 a.m., 4/14/14 at 10:30 a.m., and 4/15/14 at 10:00 a.m.</p> <p>An interview was conducted with Resident #45 on 4/15/14 at 2:32 p.m., regarding whether he had any concerns with any of the residents. He indicated he had a concern with Resident #66. He</p>	F000323	<p>ID Prefix Tag: F323-E Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Free of Accident Hazards/Supervision/Devices</p> <p>It is the policy of this facility to...</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice? ·Housekeeping Supervisor disposed of all chemicals in cabinet ·Maintenance placed a lock on cabinet in laundry room to ensure security ·Laundry Room door was locked as an extra precaution ·Fire Extinguisher Cabinets were placed over fire extinguisher to ensure they are used only during emergencies</p> <p>How will the facility identify residents having the potential to be affected by the same deficient practice? ·All ambulatory residents have the potential to be affected by this finding.</p> <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p>	05/16/2014

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	<p>stated, "One time he turned the fire alarm on, and took the fire extinguisher and sprayed someone. He walks around and tells people to get the fu** out of the way....He hangs out at the nurses desk, so I hear him yelling and swearing. It makes me want to kick his a**." Resident #45's room is directly across from the nurse's station.</p> <p>The April, 2014 Behavior Tracking and Care Plan logs for Resident #66 indicated the following:</p> <p>4/1/14, 7:45 (no a.m. or p.m. indicated) "Pulled and sprayed fire extinguisher."</p> <p>4/3/14, 5:30 p.m. "...walked over to fire pull & set off the alarm then began to laugh."</p> <p>4/6/14, 8:00 a.m. "Sprayed fire extinguisher at staff. Took x 3 CNA's (Certified Nursing Assistants) to get it away from him....He cursed and said "Da** you evil bit**."</p> <p>4/6/14, 3:55 p.m. "(Name of Resident #66) pulled the fire alarm."</p> <p>4/13/14, 6:10 p.m. "Resident called the fire department from nurses station phone."</p> <p>4/14/14, 10:30 a.m. "Resident noted tampering (symbol for "with") fire extinguisher in back hallway."</p>		<ul style="list-style-type: none"> ·Housekeeping Supervisor disposed of allchemicals in cabinet ·Maintenance placed a lock on cabinet in laundryroom to ensure security ·Laundry Room door was locked as an extra precaution and staff was in-serviced to ensure knowledge of precaution ·Protective and approved Fire Extinguisher Cabinets were placed over fire extinguisher to ensure they are used only during emergencies <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> ·Admin or designee will make daily rounds to ensure locks and cabinets are locked and in working condition daily x 2 weeks then monthly times 3 months until facility achieves 100% compliance one full quarter ·Results will be presented to the Quality Assurance Committee monthly ·The Quality Assurance committee will oversee compliance <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> ·May 16, 2014 	

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	<p>An interview was conducted with the Administrator on 4/16/14 at 10:10 a.m., regarding the above documented behaviors and Resident #66. She indicated, "He pulled the fire alarm and went about his merry way. That was the first day he got here. He did use the fire extinguisher out in the open about 2 weeks ago and sprayed, but no residents or anyone was sprayed. We did a workers comp (compensation) claim for (Name of LPN #4) just in case." She indicated QMA #1 was in the building during the incident. At this time, an observation of the fire extinguisher used by Resident #66 was made with the Administrator. The extinguisher was easily accessible, on the wall, just to the left of the nurses station. There was no container for the extinguisher. The Administrator indicated the fire extinguisher needed to be easily accessible in case of fire.</p> <p>An interview was conducted with QMA #1 on 4/16/14 at 10:40 a.m., regarding Resident #66's use of the fire extinguisher. She indicated, "I was here when he sprayed it, but I was in the back (of the facility.) I didn't walk up there, but I saw the big cloud of smoke by the pop machine and the whole building smelled like it. I know (Name of LPN</p>			

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F000329 SS=D	<p>#4) got sprayed in the eye."</p> <p>On 4/16/14 at 10:45 a.m., the Administrator provided a copy of the 4/9/14 Incident Report Form involving Resident #66. It indicated, "Brief Description of Incident: Resident (last name of Resident #17) wanted Resident (last name of Resident #66) to stop talking loudly in the middle of the night. Staff member heard some noises coming from the dining room. She headed up quickly to see what was going on. When she arrived Resident (last name of Resident #66) was falling back against the piano and Resident (last name of Resident #17) was walking out of the dining room. When questioned, Resident (last name of Resident #66) stated Resident (last name of Resident #17) punched him. Resident (last name of Resident #17) stated he want (sic) to go to sleep without any noise. Staff came in to diffuse the situation. Resident (last name of Resident #17) then returned to his room."</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse</p>			

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	<p>consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to notify a psychiatric MD/RN of a recommendation to discontinue an anti-anxiety medication in a timely manner, to provide non-medicinal approaches prior to administration of PRN (as needed) anti-psychotic and anti-anxiety medications, and to ensure detailed mental health assessments were accessible for adequate follow up and oversight of care provided for 3 of 6 residents reviewed for unnecessary medications. (Resident #17, 20 and 59)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #59 was reviewed 4/15/14 at 10:45 a.m. The diagnoses for Resident #59 included, but were not limited to, brain cancer,</p>	F000329	<p>ID Prefix Tag: F329- D Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Drug Regimen is Free from Unnecessary Drugs</p> <p>It is the policy of this facility to...</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice?</p> <ul style="list-style-type: none"> ·R#59 has been discharged ·R#20 orders were reviewed and corrections made as ordered ·R#17 has a scheduled appointment <p>How will the facility identify residents having the potential to be affected by the same deficient practice?</p>	05/16/2014

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	<p>hepatitis C, history of cerebral vascular accident, and seizure disorder.</p> <p>A review of a telephone Physician's Order, dated 11/5/13, indicated an order for haldol (anti-psychotic medication) sublingual (under the tongue) 2 mg (milligrams) every 2 hours PRN, in addition to the scheduled haldol.</p> <p>A telephone Physician's Order, dated 11/7/13, indicated an order for lorazepam intensol (anti-anxiety medication) 1 mg sublingual every hour PRN.</p> <p>A review of the December 2013 MAR (medication administration record) indicated PRN haldol was given on 12/9/13 and 12/17/13. The MAR also indicated PRN lorazepam was given on 12/20/13. Non-medicinal approached/interventions were not located in the clinical records for the above dates.</p> <p>During an interview with Director of Nursing (DoN), on 4/15/14 at 2:15 p.m., she indicated non-medicinal approaches were supposed to be tried prior to the administration of PRN anti-psychotic and anti-anxiety medications. The DoN indicated the interventions were supposed to be documented on the Behavior Tracking and Care Plan sheets.</p>		<p>·All residents receiving outside treatment and antipsychotic drugs have the potential to be affected by this finding</p> <p>·Chart Review was completed for every resident identified as having been affected by this deficient practice</p> <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p> <p>·All outside orders are dated and noted</p> <p>·A sheet listing non-pharmological interventions was initiated to offer nursing alternative non-pharmalogical interventions prior to giving PRN's</p> <p>·Nursing will be educated to this form</p> <p>How will facility monitor its corrective actions?</p> <p>·DON or designee will daily M-F review PRN medications given x 2 weeks then monthly x 3 months to ensure compliance</p> <p>·An inservice was conducted for nursing staff that addresses prn medications and process for ensuring outside orders are being reviewed. This process includes the Nurses receiving information will note, date and initial the document.</p> <p>·Don or designee will audit charts of any resident that receives outside agency services one time a week times 2 months</p> <p>·Providing the audits and</p>	

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	<p>On 4/15/14, at 3:45 p.m., the DoN indicated she was unable to locate non-medicinal approaches/interventions prior to the administration of the PRN medications listed above.</p> <p>A policy titled, Psychotropic Medication Policy, dated 5/10/13, was received by the Administrator on 4/15/14 at 3:09 p.m. The policy indicated, "...6. Prior to the initiation of psychotropic medications [sic] the resident should be assessed to rule out possible causes....Non-pharmacological interventions should be attempted and response to these interventions [sic] documented in the clinical record."</p> <p>2. The clinical record for Resident #20 was reviewed 4/14/14 at 1:45 p.m. The diagnoses for Resident #20 included, but were not limited to, vascular dementia, insomnia, spasticity, chronic pain, and anxiety.</p> <p>The February and March Physician's Orders indicated an order for lorazepam (anti-anxiety/benzodiazipne) 0.5 mg every night.</p> <p>A document from a medical doctor's (MD) appointment titled, Short Term Resident Referral, was dated 2/26/13.</p>		<p>re-education is successful she will begin auditing 2 charts monthly until 100% compliance is achieved for one full quarter</p> <ul style="list-style-type: none"> Results of the audits will be presented to the Quality Assurance Committee monthly <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> May 16, 2014 	

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	<p>The document indicated the following, "...New Orders for Health Care Center...1. Please stop lorazepam-he has dementia and avoid benzodiazipine...."</p> <p>A Psychiatric Progress Note, dated 3/31/14, indicated, "[Name of MD facility] PCP [Primary Care Physician] rec [recommend] dc [discontinue] Ativan [lorazepam]."</p> <p>During an interview with the DoN, on 4/14/14 at 1:20 p.m., she indicated the Facility Nurse Practitioner (NP) reviewed the above recommendation, but wanted to wait for the Psychiatric RN to write the order for the continuance/discontinuation of the medication. The DoN indicated that was why it took a month for the recommendation to be followed-up on, since the Psychiatric RN only comes in monthly. The DoN indicated she will look for documentation that the Facility NP reviewed the medication discontinuation recommendation.</p> <p>On 4/14/14, at 1:46 p.m., the DoN indicated there was no documentation that the Facility NP looked at the above recommendation. The DoN further indicated the Psychiatric MD/RN was not made aware of the recommendation to discontinue the medication until their visit on 3/31/14, which was over a month</p>			

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F000333 SS=D	<p>after the recommendation was made. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure an inhaler was administered properly to 1 of 4 residents observed for medication pass. (Resident #4)</p> <p>Findings include:</p> <p>During an observation of a medication pass for Resident #4, on 4/15/14 at 8:16 a.m. with QMA #1, QMA #1 gave Resident #4 his Symbicort 160/4.5 mcg (micrograms) inhaler. Resident #4 took one puff and then immediately took another puff of the medication. QMA#1 did not advise Resident #1 to wait one minute between puffs of his medication.</p> <p>During an interview with QMA #1, on 4/15/14 at 8:20 a.m., she indicated one minute was not needed between puffs with this medication.</p> <p>On 4/15/14, at 9:20 a.m., the Director of Nursing (DoN) indicated with all inhalers, a minimum of 1 minute wait time was needed between puffs.</p> <p>A policy titled, Oral Inhalation Policy</p>	F000333	<p>ID Prefix Tag: F333- D Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Resident Free of Significant Med Errors</p> <p>It is the policy of this facility to...</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice? ·R#4 was discharge prior to survey</p> <p>How will the facility identify residents having the potential to be affected by the same deficient practice? ·All residents requiring inhalers have the potential to be affected by this finding</p> <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur? ·An in-servicing was conducted with nursing including QMA's on proper administration of inhalers How will facility monitor its corrective actions?</p>	05/16/2014

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F000371 SS=F	<p>and Procedures, dated 12/17/12, was received from the DoN, on 4/15/14 at 9:20 a.m. The policy indicated, "...13. If another puff of the same or different medication is required, wait at least 1-2 minutes between puffs...."</p> <p>3.1-25(b)(9)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure proper chemical sanitization techniques were performed in the kitchen area. This had the potential to affect 47 of 47 residents at the facility.</p> <p>On 4/11/14 at 1:55 p.m., during an observation, the Dietary Manager (DM) took a test strip and placed it in a bucket filled with a chemical sanitization</p>	F000371	<p>·DON or designee will observe inhaler administration 2x weekly for 2 weeks then monthly x 6 months to ensure proper education and compliance ·Results will be presented to the Quality Assurance Committee monthly ·The Quality Assurance committee will oversee continued compliance</p> <p>Date the deficiency will be corrected? ·May 16, 2014</p> <p>ID Prefix Tag: F371- F Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Food Procure, Store/Prepare/Serve Sanitary</p> <p>It is the policy of this facility to...</p> <p>How will corrective action be accomplished for those residents</p>	05/16/2014

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	<p>solution and held it in the solution for 10 seconds. She took the strip out of the solution and the strip was pale grey in color. She indicated at that time the facility did not have a gauge for the sanitizing strips to determine what the color of the strip meant. She says she didn't know whether the pale grey appearance indicated an acceptable level of sanitization or not. She indicated she has instructed the kitchen staff on how to create a sanitizer bucket. She indicated the staff would apply two tablets of a chemical sanitizer product, labeled "Sani-Tabs", to 1 gallon of water held in a red bucket. She indicated the bucket would then keep the sanitization solution to 200-400 ppm (parts per million), referring to the chemical concentration of the solution.</p> <p>On 4/11/14 at 1:57 p.m., during an interview, the DM indicated the facility has not been keeping a record of sanitizer chemical levels for sanitizer solutions used in the kitchen area, including the low temperature dishwasher, since August of 2013. She indicated the dietary staff has not been testing the sanitizer buckets or the low temperature dishwasher with chemical sanitizer testing strips for proper chemical sanitization daily. She indicated the staff should be testing the sanitizing solutions</p>		<p>who are affected by this alleged deficient practice?</p> <ul style="list-style-type: none"> ·We obtained proper sanitation strips and began testing the dishwasher per manufacturer re: before each meal service to ensure proper chemical sanitation <p>How will the facility identify residents having the potential to be affected by the same deficient practice?</p> <ul style="list-style-type: none"> ·All residents could have the potential to be affected by this finding <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p> <ul style="list-style-type: none"> ·An in-service was conducted with all dietary staff to ensure proper testing is completed ·Tracking form initiated to monitor testing before each meal service <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> ·Admin or designee will review tracking form for accuracy and completeness daily M-F x 2 weeks and then monthly x 6 months to ensure proper education and compliance ·Results will be presented to the Quality Assurance Committee monthly ·The Quality Assurance committee will oversee compliance 	

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	<p>daily and recording them to keep track of proper sanitization.</p> <p>On 4/11/14 at 2:03 p.m., during an observation of a dishwasher cycle on the low temperature dishwasher, the dishwasher was observed to reach a temperature of 125 degrees. The DM indicated the dishwasher is maintained once a month from an outside third party and she believes they are measuring the effectiveness of the chemicals during their routine maintenance.</p> <p>The chemical sanitizing tablets labeled "SANI-TABS", indicated the following: "...For Sanitizing Food Contact Surfaces..." and "...Sanitize in a solution of 1 to 2 tabs per gallon of water (200-400ppm)..."</p> <p>On 4/16/14 at 10:21 a.m., during an interview with the dishwasher manufacturer's representative, he indicated the manufacturer recommends testing the dishwasher before each meal service to ensure proper chemical sanitization.</p> <p>A facility policy titled "Sanitizing Solution - Infection Control" indicated the following: "...Statement of purpose: to ensure sanitizing formula is correct for both food contact and non food</p>		<p>Date the deficiency will be corrected?</p> <p>·May 16, 2014</p>	

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F000425 SS=D	<p>contact..." and "...Follow manufacturer's instructions for preparing the solution in this facility 1 tablet per 1 gallon of water equals 200ppm..." The policy also indicated the sanitizing solution should be checked at 9 a.m., 12 noon, and 5 p.m.</p> <p>3.1-(21)(i)(3) 3.1-21(i)(2)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and</p>	F000425	ID Prefix Tag: F425-D	05/16/2014

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	<p>record review, the facility failed to dispose of an expired insulin and inhaler in 2 of 3 medication carts reviewed for medication storage. This affected 1 of 6 residents that received insulin from the #2 Medication Cart and 1 of 3 residents that received inhalers from the Back Hall Medication Cart. (Resident #4 and #45)</p> <p>Findings include:</p> <p>1. During an observation of the Back Hall Medication Cart with QMA #1 and Charge Nurse #2, on 4/15/14 at 10:15 a.m., Advair 250/50 (inhaler) for Resident #4 was observed with an open date of 3/12/14. Two other resident's inhalers were observed in the medication cart.</p> <p>During an interview with Charge Nurse #2, on 4/15/14 at 10:16 a.m., she indicated the above inhaler was "good" for 30 days after it was removed from the foil pouch.</p> <p>The April MAR (Medication Administration Record) for Resident #4 indicated Advair was last administered at 8 a.m., on 4/15/14.</p> <p>2. During an observation of the #2 Medication Cart, on 4/15/14 at 10:35 a.m., with QMA #3, a vial of Novolog</p>		<p>Cycle Date: November 20, 2013 Survey Date: November 20, 2013</p> <p>Pharmaceutical SVC-Accurate Procedures</p> <p>It is the policy of this facility to...</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice? ·R#4 was discharge prior to survey ·R#45 continues to receive insulin with no actual affects noted ·Med Cart was audited immediately to ensure no expired drugs were on cart</p> <p>How will the facility identify residents having the potential to be affected by the same deficient practice? ·All residents requiring insulin, eye drops, ear drops and inhalers have the potential to be affected by this finding</p> <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur? ·Med cart, Treatment cart, and Med room audit tool was established to monitor ongoing compliance ·This tool will be used weekly by RN, LPN, and/ or QMA to ensure</p>	

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	<p>(insulin) 100 units/ml for Resident #45 was observed with the open date of 2/6/14.</p> <p>During an interview with the Director of Nursing, on 4/15/14 at 10:45 a.m., she indicated insulin was considered expired after 28 days.</p> <p>On 4/15/14, at 10:49 a.m., Charge Nurse #2 indicated Resident #45 had another opened bottle of Novolog in the #2 Medication Cart that was not expired, but she was unable to determine which vial was used last.</p> <p>The April MAR for Resident #45, indicated Novolog 100 units/ml was last administered on 4/14/14 at 12:00 p.m.</p> <p>A policy titled, Recommended Minimum Medication Storage Parameters, dated 9/20/12, was received from the Administrator on 4/15/14 at 1:15 p.m. The policy indicated Advair Diskus should be discarded "one month" after removal from the foil pouch. The policy also indicated Novolog was considered expired after 28 days in room temperature.</p> <p>3.1-25(o)</p>		<p>compliance</p> <ul style="list-style-type: none"> ·Proper in-servicing will take place to ensure education on expired medication <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> ·Audit tools will be reviewed by DON or designee weekly x 4 weeks then monthly x 6 months to ensure proper education and compliance ·Results will be presented to the Quality Assurance Committee monthly ·The Quality Assurance committee will oversee compliance <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> ·May 16, 2014 				

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