

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 12, 13, 16, 17, and 18, 2015</p> <p>Facility number: 000138 Provider number: 155233 AIM number: 100266500</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 7 Medicaid: 31 Other: 21 Total: 59</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on November 30, 2015.</p>	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This facility wishes to request paper compliance.	
F 0176	483.10(n)			

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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SS=D Bldg. 00	<p>RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview and record review, the facility failed to ensure an assessment for self-administration of medications was completed and a physician's order was obtained for 1 of 3 residents reviewed for pharmaceutical services who was observed to have medications left at bedside. (Resident #56)</p> <p>Findings include:</p> <p>During an observation on 11/16/2015 at 7:30 A.M., RN (Registered Nurse) #2 prepared Resident #56's medications including levothyroxine 75 mcg (micrograms), amiodarone 200 mg (milligrams) 1/2 tablet, Protonix 40 mg, donepezil 10 mg, aspirin 325 mg, antacid 500 mg, Cardura 4 mg, docusate 100 mg, Lisinopril 2.5 mg, loratadine 10 mg, Namenda 14 mg, prednisone 5 mg, clonazepam 1 mg, and calcium +D 600 mg, by placing the medications in a medication cup. RN #2 walked into the resident's room, set the medication cup on the resident's breakfast tray and then administered the resident's Symbicort. After RN #2 administered the Symbicort,</p>	F 0176	<p>F-176</p> <p>It is the policy of this facility to ensure that medication is administered to residents according to the physician's orders as well as within accordance with the policies and procedures of the facility as well as in accordance with state and federal guidelines.</p> <p>Resident #56 currently receives his medication after his meal. Further, the nurse remains at his bedside and observes this resident as he consumes his meds. Additionally, the nurse remains with Resident #56 for the duration of his breathing treatment to ensure that it is delivered properly and so that observations can be made or cues can be given by the nurse during the course of the</p>	12/18/2015

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	<p>she left the room, leaving the medication cup, containing 14 different medications, on the resident's breakfast tray.</p> <p>During an interview on 11/16/2015 at 7:44 A.M., RN #2 indicated she has often, "in the past", left the medications for Resident #56 on his breakfast tray. RN #2 indicated the resident would not take his medications until after eating his morning meal.</p> <p>During an observation on 11/16/2015 at 9:50 A.M., Resident #56 was observed receiving a breathing treatment alone in his room. The resident was observed, sleeping, with the nebulizer mask slid up on his forehead and away from his mouth. The resident's hair was blowing up into the air above his head.</p> <p>During an observation on 11/16/2015 at 9:57 A.M., RN #2 walked into Resident #56's room, woke the resident and asked if his nebulizing treatment was completed. The mask was removed from the resident's head and the nurse left the room.</p> <p>The clinical record for Resident #56 was reviewed on 11/16/2015 at 10:34 A.M. Diagnoses included, but were not limited to, hypothyroidism, vascular dementia without behavioral disturbance, chronic</p>		<p>treatment.</p> <p>Any residents who receive medications or who receive breathing treatments have the potential to be affected by this finding.</p> <p>The DON or Designee will monitor 3 different nurses doing med passes 3 times weekly on various shifts to ensure that meds are not left at the bedside but are instead consumed in the presence of the nurse. Any attempts to leave meds at the bedside unconsumed and unobserved by the nurse will be halted and corrected as observed. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, monitoring will occur weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur.</p>	

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	<p>ischemic heart disease, chronic obstructive pulmonary disease, emphysema, chronic asthmatic bronchitis, and gastroesophageal reflux disease. Review of the physician's orders for Resident #56 indicated there was no order for the resident to self-administer medications.</p> <p>The care plans for Resident #56 were reviewed on 11/17/2015 at 9:55 A.M. Prior to the medication administration observation on 11/16/2015 at 7:30 A.M., there was no care plan in place, related to the resident being able to self-administer medication or for medications to be left at the bedside.</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 08/18/2015, indicated Resident #56 was alert and oriented with a BIMS (Brief Interview for Mental Status) score of 15.</p> <p>The current drug administration policy titled, "DRUG ADMINISTRATION-GENERAL GUIDELINES", and dated 06/19/2012, was provided by the DON (Director of Nursing) on 11/18/2015 at 10:00 A.M. The policy indicated, "...Medications are administrated as prescribed, in accordance with good nursing principles and practices...2. Medications are</p>		<p>The same monitoring will be done for residents who receive breathing treatments. The DON/Designee will monitor 3 different nurses on various shifts to ensure that the treatments are delivered properly and completely. Any concerns with any of the monitoring will be corrected immediately as discovered. The frequency of this monitoring will be the same as the</p> <p>previously stated monitoring for the med passes.</p> <p>At an inservice held 12/09/15 for the nursing staff who administer medication the facility's Policy/Procedure on Medication Administration was reviewed. This included breathing treatments. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</p>				

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F 0242 SS=D Bldg. 00	<p>administered in accordance with written orders of the attending physician...3. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the procedures for self-administration of medications..."</p> <p>The current respiratory function and therapy policy, titled "Administering Nebulizer Therapy..." was provided by the DON on 11/18/2015 at 10:00 A.M. The policy indicated, "...7. Observe expansion of chest to ascertain that patient is taking deep breaths. 8. Instruct the patient to breathe slowly and deeply until all the medication is nebulized. 9. On completion of the treatment, encourage the patient to cough after several deep breaths..."</p> <p>3.1-11(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices</p>		<p>At the monthly Quality Assurance meetings the results of the monitoring will be reviewed. Any patterns will be identified. However, any concerns will have been corrected as found. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator until resolution.</p>	

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	<p>about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to honor residents' choices regarding bathing for 2 of 3 residents reviewed for choices. (Residents #26 and #50)</p> <p>Findings include:</p> <p>1. During an interview on 11/12/2015 at 2:29 P.M., Resident #26 indicated she had asked for a bath in the past, but the staff "make her take a shower" because it costs too much to give a bath. The resident further indicated she liked a bath because of her arthritis.</p> <p>The clinical record for Resident #26 was reviewed on 11/16/2015 at 1:49 P.M. Diagnoses included, but were not limited to, a history of falls, arthritis, atrial fibrillation and hypertension. The admission MDS (Minimum Data Set) assessment, dated 04/22/2015, indicated Resident #26 was alert and oriented with a BIMS (Brief Interview for Mental Status) score of 15. The assessment further indicated it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath, and the resident required assistance of one staff member for bathing.</p> <p>The complete and current care plan was provided by the MDS Coordinator on</p>	F 0242	<p>F-242</p> <p>It is the policy of this facility to ensure that residents exercise their right to make choices that relate to the activities of their daily lives within the facility.</p> <p>Resident #26 currently receives a tub bath twice weekly or more if she so desires or needs. She has had a new "Bathing and Bedtime Choices" form completed and her care plan has been updated. Resident #50 currently receives a complete sponge/bed bath twice weekly or more as per her need or preference. She too has had a new "Bathing and Bedtime Choices" form completed and her care plan has been updated as well. CNA instruction information has been updated for each of these residents.</p>	12/18/2015

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	<p>11/17/2015 at 11:00 A.M. and reviewed at that time. The care plan indicated the resident required assistance with ADL's (Activities of Daily Living) and indicated an intervention of, "shower two times a week and as needed". Resident #26 was also care planned for the potential for pain related to arthritis. No intervention was listed for soaking in a warm tub.</p> <p>During an interview on 11/17/2015 at 2:44 P.M., the Activities Director indicated if a resident prefers a tub bath, she informs the Administrator and the DON (Director of Nursing) and hopes that they accommodate the resident's choice. She further indicated an interview was conducted with each resident upon admission and quarterly regarding resident choices.</p> <p>During an interview on 11/18/2015 at 10:35 A.M., the DON indicated the facility did have a tub for resident's use.</p> <p>Record review of the "Bathing and Bedtime Choices" form, provided by the Social Services Director on 11/17/2015 at 3:14 P.M., indicated residents are offered a choice between a shower and a bed bath; a tub bath was not listed on the form as an option.</p> <p>During an observation on 11/18/2015 at</p>		<p>Any resident who resides in the facility and receives care has the potential to be affected by this finding. They or, if they are unable to respond, their families have the right to make decisions pertaining to their care. The "Bathing and Bedtime Choices" form has been revised to include showers, tub baths and sponge/bed baths. All residents have had a new form filled out as the form has been revised. Families have been contacted for input for residents unable to answer for themselves. Care plans and CNA instruction information has been updated. Going forward, these forms will be completed and reviewed upon admission, upon a resident's request as well as at the care plan meetings. The Activity Director/Designee will monitor 5 residents weekly to ensure that their personal choices are correctly reflected on the Bathing and Bedtime Choices form. Any changes will be made and followed</p>		

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	<p>4:07 P.M., the recently refurbished rehabilitation hall was observed. The shower room contained a new bathtub and fixtures. A shower chair was sitting in the tub.</p> <p>2. During an interview on 11/13/2015 at 10:04 A.M., Resident #50 indicated she preferred to take a bed bath. The resident further indicated it was really hard for her to be in the shower and she had indicated to staff that she would prefer to have a bed bath, but the staff told her she had to take a shower. Resident #50 indicated the staff did not wash the seat off in the shower after every person. "They just take a towel and wipe it off." Resident #50 indicated she had seen stuff on the shower seat even after the staff had wiped it off. Resident #50 indicated staff could wash her hair in the beauty shop and it was easier to sit in the bathroom in her room and get her back washed, than it was to get in the shower.</p> <p>The clinical record for Resident #50 was reviewed on 11/16/2015 at 1:39 P.M. The annual MDS assessment, dated 03/04/2015, indicated it was "very important" for the resident to choose between a tub bath, shower, bed bath, or sponge bath. The assessment further indicated the resident was alert and oriented with a BIMS score of 14.</p>		<p>through to the care plan and the CNA instruction information. This monitoring will occur until 4 consecutive weeks of zero negative findings are achieved. Afterwards, monitoring will continue at the rate of at least 1 resident weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur.</p> <p>At an inservice held for all staff 12/09/15 Resident's Rights was reviewed with emphasis on the resident's right to choose as much as possible as related to their life and care within the facility. Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as indicated.</p> <p>At the monthly QA meetings the results of the monitoring for choices being honored will</p>		

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F 0244	<p>The complete and current care plan was provided by the MDS Coordinator on 11/17/2015 at 11:00 AM. and reviewed at that time. Diagnoses included, but were not limited to, peripheral vascular disease, major depressive disorder and age related osteoporosis. A care plan focus listed, "Declines showers multiple times in a row and states she washes herself in sink in room." One of the interventions listed was, "Offer choices". Another focus listed in the care plan was, "Resident is resistant/declines care AEB (As Evidenced By): declines ... showers." One of the interventions listed indicated, "Explain safety importance and care choices".</p> <p>The AD (Activities Director) was interviewed on 11/17/2015 at 2:01 P.M. She indicated, following interviews with the resident or family regarding bathing preferences, she passed the information on to the IDT (Interdisciplinary Team) specifying the resident's preferences for bathing. She further indicated residents are reassessed at least quarterly.</p> <p>3.1-3(v)(1)</p> <p>483.15(c)(6)</p>		be reviewed, however any concerns will have been corrected as found. If needed an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.		

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SS=E Bldg. 00	<p>LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to respond to and resolve the grievances brought forth by the Resident Council in a timely manner, related to food quality, temperature, and menus, for 7 of 11 months of Resident Council Meeting Minutes reviewed.</p> <p>Findings include:</p> <p>On 11/16/2015 at 10:25 A.M., the Resident Council minutes were reviewed with permission from the Resident Council President. Food quality was a concern for the months of January, February, March, June, July, September, and November. Menu selections and substitutions were a concern in March and May and food temperatures were listed as a concern in January, August, and November.</p> <p>During an interview on 11/16/2015 at 11:00 A.M., the Resident Council President indicated after the meetings, the council's concerns are sent to the different departments for review and</p>	F 0244	<p>F-244</p> <p>It is the policy of this facility to see that grievances or concerns brought forth by the Resident Council are addressed and responded back to in a timely manner. Currently, concerns are being addressed timely.</p> <p>The Activity Director will present all concerns raised by the Resident Council to the Administrator and the Department Head team at the next CQI morning meeting following the Resident Council meeting. The appropriate Department Head will receive the concern and will</p> <p>develop a plan to resolve the</p>	12/18/2015

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	<p>those departments say they are going to make changes regarding the resident's concerns. The Resident Council President indicated there have been the same concerns each month and most of them have to do with the food. He indicated the same concerns about food are brought up each month because nothing is done about the resident's concerns.</p> <p>During an interview on 11/16/2015 at 2:10P.M., the Activities Director (AD) indicated the Resident Council meets monthly, on the third Tuesday of each month, in the main dining room. The AD indicated at the end of each meeting the concerns are written up and delivered to each department involved and to the Administrator. Each department head has 24 hours to create their plan of action to address the residents concerns. She indicated food concerns were common.</p> <p>During an interview on 11/18/2015 at 12:45 P.M., the Dietary Manager (DM) indicated when concerns are brought from the Resident Council meeting, if the concern had to do with the kitchen staff she re-trains or re-coaches the staff members. The DM indicated if the concerns were about food quality, she contacts the food provider to request and order a better quality of food. She requests menu changes that are more</p>		<p>concern by the next CQI meeting. Within 72 hours of the concern being presented, the Administrator will validate the plan to address the concern. The Activity Director will discuss the plan to resolve the issue with the Resident Council president at that time. It will be discussed with the group (Resident Council) at the next meeting. Of course, any issue that involves safety will be immediately addressed as soon as presented by the Resident Council.</p> <p>Food quality, food temperatures and menus/substitutions have been addressed and discussed with the Resident Council to the council's satisfaction.</p> <p>All residents who reside in the facility especially those who consume meals prepared by the dietary department have the potential to be affected by this finding.</p>	

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	<p>suited for residents in this region. She indicated menus and menu changes are reviewed with the Dietitian.</p> <p>3.1-3(I)</p>		<p>The Dietician along with the Administrator and the Dietary Manager have met with the Resident Council to discuss food quality, food temperatures and menus/substitutions.</p> <p>After this meeting, the Dietician and the Administrator as well as the Dietary Manager met.</p> <p>They discussed the action to be taken. Going forward, the Dietary Manager/Designee will monitor 10 residents weekly at different meal times to assess satisfaction with:</p> <ul style="list-style-type: none"> a. Food Quality b. Food Temp c. Availability of substitutions d. Menu in general 	

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			<p>Any concerns will be addressed as discovered. The monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Then monitoring will occur with at least 5 residents weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: The Dietary Manager will request permission to discuss any dietary related concerns with the Resident Council at least quarterly or as needed.</p> <p>At an inservice held for dietary staff 12/09/15 the following was reviewed:</p> <ul style="list-style-type: none"> a. Food Quality/Preparation b. Food Temps maintained c. Availability of substitutions 	

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			<p>d. Menu in general/following</p> <p>Additionally, the Administrator inserviced the Department Heads on the process of addressing Resident Council concerns presented to them and the expectation of their response/plan.</p> <p>Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</p> <p>The results of the monitoring by the Dietary Manager/Designee will be reviewed at the QA meetings monthly. However, any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will</p>	

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F 0425 SS=D Bldg. 00	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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 record review, the facility failed to provide routine medications, as evidenced by failure to reorder a resident's stool softeners timely, for 1 of 3 resident reviewed for pharmaceutical services. (Resident #56)</p> <p>Findings include:</p>	F 0425	<p>be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolution.</p> <p>F-425 It is the policy of this facility to see that meds are ordered and reordered using a process that ensures that meds are available to be administered according to the physician's orders. Currently, Resident #56 receives his meds timely and according to the physician's order. All residents who reside in the facility and who receive</p>	12/18/2015

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	<p>The clinical record for Resident #56 was reviewed on 11/16/2015 at 10:34 A.M. Diagnoses included, but were not limited to, hypothyroidism, vascular dementia without behavioral disturbance, and gastroesophageal reflux disease. Resident #56 was prescribed Colace 100 mg and Miralax 17 g to be taken at 8:00 A.M. daily.</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 08/18/2015, indicated Resident #56 was alert and oriented with a (BIMS) Brief Interview for Mental Status score of 15.</p> <p>The care plan for "Potential for bowel irregularity r/t dx (related to the diagnosis): decreased bowel motility", initiated on 06/19/2014, indicated the interventions included, but were not limited to, "...meds per order..."</p> <p>During an observation on 11/16/2015 at 7:30 A.M., RN (Registered Nurse) #2 prepared Resident #56's medications. The resident was out of the following three medications: docusate 100 mg (milligrams), Miralax 17 g (grams), Calcium + D 600 mg. RN #2 was able to acquire the docusate and Calcium + D from the EDK (Emergency Drug Kit). Resident #56 was not observed to receive</p>		<p>meds supplied by the pharmacy and ordered by the nursing staff have the potential to be affected by this finding. The DON has had dialogue with the pharmacy related to medication deliveries. Also, the DON will discuss the possibility of having Miralax as well as Colace included in the supply of back up meds. Resident meds should be available timely going forward. The DON/Designee will monitor the timeliness of medication deliveries daily. This will be documented. Any concerns will be documented and immediately researched. Meds will be obtained from the back up pharmacy as necessary to keep med administration timely. This monitoring will be ongoing. At an inservice held 12/09/15 for nursing staff who administer meds the following was reviewed: a. Ordering of meds: process/timeliness/documentation b. What is in EDK/Back up meds? c. What to do if a med is missing? d. Pharmacy: when/how/who to contact? e. Back up pharmacy procedure Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as needed. At the monthly QA meetings the results of the monitoring will be reviewed. However, any concerns will have been addressed as found. If necessary, an Action Plan will be</p>				

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	<p>the scheduled dose of Miralax (laxative). RN #2 placed the cup of medications on the resident's breakfast tray and left the resident's room.</p> <p>During an interview on 11/16/2015 at 7:44 A.M., RN #2 indicated Resident #56 was out of Miralax and she would not be able to administer the medication until the pharmacy delivered the prescription. She further indicated the other two medications were in the EDK.</p> <p>During an interview on 11/16/2015 at 7:55 A.M., Physician #8 indicated there had been issues with residents missing their medications due to a delay in filling medication orders.</p> <p>During an interview on 11/16/2015 at 1:50 P.M., the DON (Director of Nursing) indicated there had been some issues of the medications running late on refills. When reviewing Resident #56's medications, the DON indicated no note was found from RN #2 requesting medication refills for Resident #56 on 11/16/2015. RN #2 left at 12:00 P.M. on 11/16/2015. The DON indicated the medications are ordered through the EMR (Electronic Medical Record) and the button was greyed out indicating the medications should be on order. The DON further indicated she felt there was</p>		written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.				

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	<p>a delay in the process.</p> <p>During an interview on 11/17/2015 at 12:58 P.M., Pharmacist #9 indicated Resident #56's Calcium + D 600 mg was ordered yesterday and filled yesterday, the order for Miralax, aspirin and Colace was received that day, 11/17/2015. The Pharmacist further indicated most prescriptions were filled the same day when a request was received by 1:00 P.M. or by the next day if received after that time. If a prescription is marked ASAP (as soon as possible) the prescription was filled immediately.</p> <p>During an interview on 11/17/2015 at 1:09 P.M., QMA (Qualified Medication Aide) #10 indicated Resident #56 did not receive his Colace or Miralax that day. She further indicated that both medications had been ordered twice. QMA #10 indicated there had been an issue with the EMR, if the medication request was over 14 characters [in length] the request was delayed and a fax needed to be sent to the pharmacy.</p> <p>During an interview on 11/17/2015 at 1:23 P.M., Resident #56 indicated he was having a hard time getting his bowels to move. The resident further indicated his stools were hard and he could only pass a very small amount of stool that day.</p>			

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F 0431 SS=D Bldg. 00	<p>The current drug administration policy titled, "DRUG ADMINISTRATION-GENERAL GUIDELINES", and dated 06/19/2012, was provided by the DON on 11/18/2015 at 10:00 A.M. The policy indicated, "...Medications are administrated as prescribed, in accordance with good nursing principles and practices..."</p> <p>3.1-25(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under</p>						

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	<p>proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to follow current, acceptable practice for the disposal of expired medications, related to the use Tubersol (medication used for tuberculin skin testing) for the general population, for 1 of 5 medication storage areas. (Medication storage room)</p> <p>Findings include:</p> <p>On 11/17/2015 at 2:13 P.M., an observation of the medication storage room was conducted with LPN (Licensed Practical Nurse) #4. Two open multi-dose vials labeled "Tubersol" were located in the #3 refrigerator inside the medication storage room. According to the manufacturer's guidelines, Tubersol which had been opened and in use for 30 days, should be discarded. One Tubersol vial was opened on 02/20/2015 indicating an expiration date of 03/22/2015. The</p>	F 0431	<p>F-431</p> <p>It is the policy of this facility to see that all meds that meet the criteria for meds that need to be discarded are in fact discarded when expired. Currently, med storage rooms and other storage areas like med carts do not contain meds that are expired.</p> <p>All residents who receive meds stored in the facility have the potential to be affected by this finding. The DON/Designee will monitor/audit all areas where meds are stored 3 days weekly</p>	12/18/2015

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	<p>second open vial of Tubersol was not labeled with an open date, but was received from the pharmacy on 07/20/2015, indicating an expiration date of 08/19/2015.</p> <p>During an interview on 11/17/2015 at 2:17 P.M., LPN #4 indicated the expired vials of Tubersol were used on the general population and staff. She further indicated the vial opened on 02/22/2015 should have been properly disposed of and not in the medication storage area. LPN #4 indicated she was not sure about the second open vial received on 07/20/2015.</p> <p>During an interview on 11/17/2015 at 2:54 P.M., the DON (Director of Nursing) indicated the facility follows the manufacturer's guidelines and the expired Tubersol vials should have been properly disposed of and not in the medication room. The DON further indicated the Tubersol was used for the general population and staff.</p> <p>The current medication storage policy titled, "MEDICATION STORAGE IN THE FACILITY", and dated 06/19/2012, was provided by the DON on 11/18/2015 at 10:00 A.M. The policy indicated, "...#14. Outdated, contaminated, or deteriorated drugs ... will be immediately</p>		<p>to check for expired meds that need to be discarded. Any found will be immediately and appropriately disposed of. This monitoring will continue until 4 consecutive weeks of zero</p> <p>negative findings are achieved. Afterwards, weekly audits will occur for a period of not less than 6 months to ensure ongoing compliance. After that, random audits will occur.</p> <p>At an inservice for nursing staff who administer meds held 12/09/15, the policies on Medication Administration and Medication Storage were reviewed. There was emphasis on expired medications and the necessity</p>	

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F 0496 SS=D Bldg. 00	<p>withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists... #18. Facility staff will assure that the multi dose vial is stored following manufacturer's suggested storage conditions..."</p> <p>3.1-25(o)</p> <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and</p>		<p>to discard them timely and appropriately. Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as indicated.</p> <p>At the monthly QA meetings the results of the monitoring of expired meds will be reviewed. Any patterns will be identified, however any concerns will have been addressed as discovered.</p> <p>If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolution.</p>	

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	<p>competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on record review and interview, the facility failed to ensure each employee had current licensure or certification, this affected 1 of 24 employees (CNA #1) and had the potential to affect 59 of 59 residents residing in the facility.</p> <p>Findings include:</p> <p>Employee records were reviewed on 11/18/2015 at 10:30 A.M. CNA (Certified Nursing Assistant) #1's certification was found to be expired as of 04/29/2015.</p>	F 0496	<p>F-496</p> <p>It is the policy of this facility to ensure that all staff who have who have a license or a certificate have their credentials kept current. All staff who have a license or a certificate including CNA #1 have current credentials.</p> <p>All residents in the facility</p>	12/18/2015	

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	<p>Staffing records, provided by the BOM (Business Office Manager) on 11/18/2015 at 12:28 P.M. indicated CNA #1 worked the following days as a CNA:</p> <p>September 6, 8, 9, 10, 15, 16, 17, 19, 20, 22, 23, 24, 29, and 30, 2015 October 1, 3, 4, 6, 7, 8, 13, 14, 15, 17, 18, 21, 22, 23, 27, 28, 29, and 31, 2015</p> <p>During an interview on 11/18/2015 at 11:30 A.M., the DON (Director of Nursing) indicated CNA #1's certification was found to be expired recently and that CNA #1 had been working as a Helping Hand (unlicensed work) since it was discovered. The DON further indicated CNA #1 had been working in the facility as a CNA since the license had expired in April until they noticed it was expired recently.</p> <p>During an interview on 11/18/2015 at 12:09 P.M, CNA #1 indicated the facility let her know that her license had expired once they noticed it and that she had been working, unaware it had expired, before that. The CNA further indicated she had been working on getting her CNA certification renewed and that she had been working as a Helping Hand since they let her know about the expired certification.</p>		<p>have the potential to be affected by this finding. Going forward, the</p> <p>Business Office Assistant who keeps track of the employee files will ensure that all staff who have a license or a certificate (pertinent to their job) have that credential current with a copy in their employee file. LPNs and RNs have their license renewed alternating years in October. However, CNAs can vary. There will be a "tickler file" kept that will be reviewed weekly by the keeper of the employee files. Any upcoming renewal needs will be shared with the Administrator as well as the employee. It will be explained to the employee that they will be taken off the schedule should they fail to renew their credentials timely. This weekly verification of timely credentials will be an ongoing process going forward.</p>	

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	3.1-14(s)		<p>At an inservice held for all staff the necessity to have any needed credential (copy) within their employee file was reiterated. Any staff who fail to comply will be removed from the schedule until the proper paperwork (license or certificate) is obtained.</p> <p>At the monthly QA meetings, the keeper of the employee files will discuss any trending with the licenses or certificates. This will be monitored as stated previously by this person and the Administrator as a joint effort on going. Any patterns will be reviewed, however any staff who are not current with this requirement will have been removed from the schedule pending compliance.</p>	