

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155136	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/18/2013
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVE LA PORTE, IN 46350
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigaton of Complaint IN00127125.</p> <p>Survey dates: April 11,12, 15, 16, 17 &amp; 18, 2013</p> <p>Facility number: 000061 Provider number: 155136 AIM number: 100288620</p> <p>Survey Team: Kathleen (Kitty) Vargas, RN-TC Heather Tuttle, RN Lara Richards, RN (4/11, 4/12, 4/15, 4/17, 4/18, 2013) Shannon Pietrawszewski, RN (4/11, 4/12, 4/15, 4/17, 4/18, 2013) Cynthia Stramel, RN. (4/11, 4/12, 2013)</p> <p>Census Bed Type: SNF/NF: 129 Total: 129</p> <p>Census Payor Type: Medicare: 21 Medicaid: 102 Other: 6 Total: 129</p>	F000000	<p>This Plan of Correction shall serve as this facility's credible allegation of complinace. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirments identified in this survey. Respectfully Submitted, Beth IngramExecutive Director</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiencystatement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 25, 2013, by Janelyn Kulik, RN.</p>			
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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each residents' dignity was maintained related to being called "sweetie", "honey" and "doll" for 1 of 1 treatments observed and for 1 of 1 meals observed on the Terrace Garden Unit. This had the potential to affect the 43 residents residing on the Terrace Garden Unit. (Residents # 25 and #178)</p> <p>Findings include:</p> <p>1. On 4/11/13 at 12:01 p.m., in the Terrace Garden dining room, CNA #2 was observed to call Resident #178 "honey".</p> <p>Interview with RN #5 on 4/18/13 at 9:30 a.m., indicated the residents should be addressed by their name and not addressed as "honey" or "sweetie". The RN also indicated an inservice would be held to educate the staff on the unit.</p> <p>2. On 4/17/13 at 9:09 a.m., a</p>	F000241	<p>Step One:A psychosocial assessment was completed for Resident #178 and #25 with no adverse effects noted related to being addressed as "Honey, Sweetie, and/or Doll."Step Two:All residents were interviewed and questioned if staff address each resident by speaking respectfully and using the name of resident choice. No deficiencies were noted.Step Three:All staff were re-educated regarding resident dignity and addressing residents by the name of resident choice. The DNS and/or designee will conduct dignity rounds three times weekly to ensure that resident dignity is maintained at all times. The DNS will report any trends or findings to the QAPI Committee monthly.Step Four:The results of the dignity rounds will be reviewed three times weekly during the Clinical Start-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3</p>	05/18/2013

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	<p>pressure ulcer treatment was observed for Resident #25. RN #5 addressed the resident as "doll" and "honey" several times during the treatment.</p> <p>Interview with RN #5 on 4/18/13 at 9:30 a.m., indicated that she should have addressed the resident by her name rather than "honey" or "doll". The RN also indicated an inservice would be held to educate the staff on the unit.</p> <p>3.1-3(t)</p>		deficient practices per month will be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee.		

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F000278 SS=A	<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 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 record review and interview, the facility failed to ensure each resident's comprehensive assessment was accurate related to Psychotropic medication for 3 of 21 residents reviewed for comprehensive assessments. (Resident's #40, #101, and #132)</p>	F000278	<p>Step One: The medication section of the MDS were modified to reflect the correct number of days that each resident received psychotropic medication for Residents #40, #101, and #132. Step Two: The medication section of the current MDS for all residents receiving psychotropic medications were audited to</p>	05/18/2013	

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	<p>Findings include:</p> <p>The record for Resident #132 was reviewed on 4/16/13 at 8:10 a.m. The resident's diagnoses included, but were not limited to, psychoses, depressive disorder, and dementia with behavioral disturbances.</p> <p>Review of the quarterly 4/3/13 Minimum Data Set (MDS) assessment indicated the resident was receiving an antidepressant seven days a week. Antipsychotic medication was coded with a "0" indicating the resident was not receiving any of that medication.</p> <p>Review of the Physician Orders dated 1/21/13, indicated Abilify (an antipsychotic medication) 2 milligrams (mg) daily was ordered.</p> <p>Interview with the MDS Coordinator on 4/16/13 at 10:56 a.m., indicated the resident was receiving the Abilify in January, February, March, and April 2013. She further indicated the MDS under the medication section for antipsychotics should have been coded with a "7" indicating the resident had received the medication in the last seven days.</p>		<p>ensure the correct coding of the number of days each resident received psychotropic medications. Any deficiencies noted were corrected. Step Three: The MDS Coordinators were re-educated regarding accurate coding of the medication section of the MDS. The DNS and/or designee will audit the medication section of the MDS for three residents weekly to ensure accurate coding of the MDS. The DNS will report any trends or findings to the QAPI Committee monthly. Step Four: The results of the medication section audit will be reviewed three times weekly during the Clinical Start-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee</p>				

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	<p>2. The record for Resident #40 was reviewed on 4/15/13 at 1:17 p.m. The resident's diagnoses included, but were not limited to, psychosis, anxiety, dementia, depressive disorder, and insomnia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 3/28/13 indicated the resident received an antidepressant seven days a week. Antipsychotic and antianxiety medications were coded with a "0", indicating the resident was not taking any of those medications.</p> <p>Review of Physician Orders dated 8/15/12 indicated the resident was receiving Buspar (an antianxiety medication) 10 milligrams (mg) daily and Abilify (an antipsychotic medication) 2 mg daily.</p> <p>Interview with the MDS Coordinator on 4/16/13 at 2:45 p.m., indicated the MDS medication section was inaccurately coded for the antianxiety and antipsychotic medications.</p> <p>3. The record for Resident #101 was reviewed on 4/15/13 at 8:26 a.m. The resident had diagnoses that included, but were not limited to, depression and anxiety.</p>						

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	<p>The January 2013 Medication Administration Record (MAR) was reviewed. It indicated the resident received Remeron (an anti-depressant medication) and Zoloft (an anti-depressant medication) daily, from January 1st through January 31st.</p> <p>The February 2013 MAR was reviewed. It indicated the resident received Remeron and Zoloft daily from February 1st through February 28th.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 2/5/13, was reviewed. Antidepressant medication was coded with a "0", indicating the resident was not receiving that medication.</p> <p>On 4/15/13 at 1:11 p.m., the MDS Coordinator was interviewed. She indicated the MDS was inaccurately coded. She indicated the resident was receiving Zoloft and Remeron and the MDS should have been coded "7" which indicated that the resident received an antidepressant for 7 days.</p> <p>3.1-31(d)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 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 observation, record review, and interview, the facility failed to ensure each resident was free from unnecessary medication related to gradual dose reductions for antianxiety medications and antidepressant medications and for the indication and duplicate drug therapy of the use of an antidepressant medication for 3 of 10 residents reviewed for unnecessary medications. (Resident's #40, #101, and #125)</p>	F000329	<p>Step One: Resident #40, #125, and #101 were re-evaluated for use of antidepressant and/or antianxiety medications. New orders were obtained for discontinuation of medication, gradual dose reduction, or appropriate documentation of rationale for continued use of the medication. Step Two: All residents with current orders for psychotropic medication were re-evaluated to ensure that appropriate gradual dose reductions and/or documentation of duplicate therapy are present.</p>	05/18/2013			

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	<p>Findings include:</p> <p>1. The record for Resident #40 was reviewed on 4/15/13 at 1:17 p.m. The resident's diagnoses included, but were not limited to, psychosis, anxiety, dementia, depressive disorder, and insomnia.</p> <p>Review of the 3/28/13 quarterly Minimum Data Set (MDS) assessment indicated the resident was alert and oriented, had some mood issues regarding feeling bad about herself, trouble with concentration, and feels tired. The resident was also noted to be taking an antidepressant seven days week.</p> <p>Review of Physician Orders indicated the resident was receiving Wellbutrin (an antidepressant) 75 milligrams (mg) twice a day since 3/7/13. The resident was also receiving Lexapro (an antidepressant) 20 mg daily since 6/16/11. The resident was receiving Remeron (an antidepressant) 7.5 mg since 12/12/12. The resident was receiving Buspar (an antianxiety) 10 mg since 8/15/12 and Abilify (an antipsychotic) 2 mg since 1/15/13.</p> <p>Review of the behavior monitoring sheets for the months of 1/2013,</p>		<p>Any deficiencies noted were corrected. Step Three: Licensed Nursing Staff were re-educated regarding the F329 requirements for gradual dose reductions for psychotropic medications and the requirement for documentation of indications for use of duplicate therapy. The DNS and/or designee will audit all current psychotropic medication orders monthly for appropriate gradual dose reductions and/or documentation for continued use or duplicate therapy. The DNS and/or designee will report any trends or findings to the QAPI Committee monthly. Step Four: The results of the psychotropic medication audit will be reviewed monthly during the Clinical Start-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee</p>		

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	<p>2/2013 and 3/2013 indicated the resident was being monitored for depression. There were no episodes recorded.</p> <p>Review of the Nurse Practitioner progress notes from the psychiatric services dated 3/18/13, indicated the resident had a history of depression, but denies current symptoms of depression although does feel sad sometimes.</p> <p>Review of the pharmacist consultation report dated 3/14/13, indicated the resident receives Wellbutrin, Lexapro, and Remeron. Please consider a gradual dose reduction. Further review of the consultation report indicated the Nurse Practitioner documented, "Patient is stable. Remeron is for appetite. Patient doing well and change is not applicable at this time."</p> <p>Review of the Nutrition progress notes dated 3/26/13, indicated the resident's admission weight was 207 pounds, the resident's ideal body weight range was between 121-149 pounds. The resident's Body Mass Index (BMI) indicated obese status, gradual weight loss beneficial.</p> <p>Review of the Nutrition Progress note</p>						

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	<p>dated 1/3/13, indicated the resident's December monthly weight was 210 pounds. The BMI indicated obese status, gradual weight loss beneficial.</p> <p>Review of the weight record indicated the resident's weights were as follows:</p> <p>4/8/13 208 3/10/13 209 1/9/13 206 12/2012 12 210 11/2012 218 10/2012 213</p> <p>Further record review indicated the resident's weight was stable, but above her ideal body weight range and above her BMI.</p> <p>Continued record review indicated there was no documentation of any gradual dose reduction for the Lexapro and/or the Buspar medication since the resident first started receiving them.</p> <p>Interview with the Memory Care Unit Manager on 4/16/13 at 1:22 p.m., indicated the last Remeron dose reduction was 12/12/12.</p> <p>Interview with the Memory Care Unit Manager on 4/16/13 at 3:06 p.m.,</p>						

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	<p>indicated there have been no gradual dose reductions for the Buspar and Lexapro medications. She further indicated the resident's weight was stable and the Remeron medication should be discontinued.</p> <p>2. The record for Resident #125 was reviewed on 4/15/13 at 10:32 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, psychosis, depressive disorder, psychogenic paranoid psychosis, insomnia, and dementia with behavioral disturbances.</p> <p>Review of the 2/21/13 quarterly Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented, she was receiving an antipsychotic, antianxiety, and antidepressant medication seven days a week. The resident had trouble concentrating on things such as reading the newspaper, moving or speaking slowly. The resident was also fidgety or restless,</p> <p>Review of Physician Orders dated 3/29/13, indicated Trazadone (an antidepressant) 100 milligrams (mg) at night. The indication for use was to treat insomnia.</p>						

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	<p>Review of the behavior sheets for the months of 1/2013, 2/2013, 3/2013, and 4/2013, indicated there was no documentation the resident was having trouble falling asleep.</p> <p>Review of Physician Progress noted dated 3/29/13, indicated there was no documentation by the Nurse Practitioner as to why the Trazadone was started on that date. The Nurse Practitioner wrote the order on 3/29/13.</p> <p>Review of the Psychiatric services dated 4/1/13, indicated the resident has a history of depression and behavioral disturbances, she complains of feeling sad at times, no behaviors noted during interview.</p> <p>Review of Physician Progress Notes dated 1/25/13, indicated continues to struggle with insomnia, agitated/restless until 3 a.m., then tires finally. This was the only documentation of insomnia by the Physician.</p> <p>Review of Physician Progress Notes dated 3/27/13, indicated confused and anxious wringing hands and twisting a paper. Mild increase of anxiety today. There was no documentation the resident was</p>						

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	<p>having complaints of insomnia.</p> <p>Review of Social Service Progress Notes dated 3/20/13, 4/8/13, and 4/11/13, indicated no documentation the resident was having difficulty with falling asleep.</p> <p>Review of Nursing Notes dated 3/21 at 12:26 a.m., indicated the resident was in bed, awake currently making noises, hitting on her bed, and singing. Another Nursing Note dated 3/28/13 at 2:26 a.m., indicated the resident had intermittent periods of agitation this shift. Yells out for family.</p> <p>Interview with the Memory Care Unit Manager on 4/16/13 at 2:50 p.m., indicated there was no documentation to support the indication for use for the Trazadone.</p> <p>3. Resident #101 was observed on 4/12/13 at 2:26 p.m., seated in a wheelchair in the Fireside Lounge. The resident was calm.</p> <p>The resident was observed on 4/15/13 at 9:05 a.m., seated in a wheelchair. She was in the Fireside Lounge eating breakfast. She was calm.</p>				

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	<p>The resident was observed on 4/15/13 at 11:03 a.m. She was seated in a wheelchair in the Fireside Lounge, the resident was calm, her eyes were closed.</p> <p>On 4/16 13 at 8:21 a.m., the resident was in The Fireside Lounge eating breakfast. She was alert and was smiling, she was calm.</p> <p>The record for Resident #101 was reviewed on 4/15/13 at 8:26 a.m. The resident had diagnoses that included, but were not limited to, depression, dementia and anxiety.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 2/5/13, was reviewed. It indicated the resident received an antianxiety medication for 7 of the past 7 days.</p> <p>There was a Physician Order, dated 5/21/12, that indicated, Ativan (an antianxiety medication) 0.25 mg (milligrams) was to be administered twice daily.</p> <p>On 6/7/12 there was a Physician's Order to increase the Ativan to 0.5 mg twice daily.</p> <p>There was a Physician Order, dated</p>						

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	<p>6/29/12, to increase the Ativan to 0.5 mg three times a day.</p> <p>Review of the resident's current physician's orders, indicated the resident was receiving Ativan 0.5 mg three times per day. The resident had received the same dose of Ativan since 6/29/12.</p> <p>Review of the resident's record indicated there was no physician order to reduce the medication.</p> <p>Review of the resident's behavior sheets dated July 2012, August 2012, September 2012, October 2012, November 2012, December 2012, January 2013, February 2013 and March 2013, indicated the resident was monitored for anxiety. The behavior sheets indicated there were no episodes of anxious behavior exhibited by the resident.</p> <p>Interview with the Assistant Director of Nursing Services on 4/16/13 at 2:22 p.m., indicated there were no attempts to reduce the use of Ativan since it was initiated on 5/21/12. She indicated attempts to reduce the medication should have been attempted.</p> <p>3.1-48(a)(2)</p>				

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	3.1-48(a)(4)			

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F000425 SS=E	<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, record review, and interview, the facility failed to ensure medication carts were free from loose medications not contained in the medication cards for 4 of 8 medication carts observed in 2 of 3 units. (Rainbow Lane and Memory Lane). This had the potential to affect 51 residents who resided on Rainbow Lane and 35 residents who resided on Memory Lane.</p> <p>Findings included:</p> <p>1. During medication storage observation on Rainbow Lane on</p>	F000425	<p>Step One:All loose medication were appropriately disposed per policy.Step Two:All medication carts were inspected for the presence of loose medications. No other loose medications were noted.Step Three:All Licensed Nurses were re-educated regarding the Medication Storage Policy. The DNS and/or designee will inspects all medicaton carts two times weekly to ensure that there are no loose pills in the medication carts. The DNS will report any trends or findings to the QAPI Committee monthly.Step Four:The results of the medication cart audits will be reviewed two times weekly during</p>	05/18/2013	

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	<p>4/17/13 at 1:20 p.m., the following pills were observed in the drawers of the medication carts:</p> <p>a. Medication cart number two had 20 loose pills and capsules in 2 of 3 drawers.</p> <p>b. Medication cart number one had 4 loose pills in 2 of 3 drawers.</p> <p>c. Medication cart number three had 28 loose pills and capsules in 2 of 3 drawers.</p> <p>LPN #7 and LPN#5 acknowledged the loose pills in the drawers during this time. LPN #7 indicated she did not know how often the medication carts were cleaned out. LPN #5 indicated she works on all the units and tries to pull out loose pills as she finds them.</p> <p>2. During medication storage observation on Memory Lane on 4/17/13 at 2:30 p.m., medication cart number one had 4 loose pills in 1 of 3 drawers.</p> <p>The Unit Manager acknowledged the loose pills in the drawer during this time.</p> <p>The policy for Medication Storage/Storage of Medication dated 09/08, was provided by the Director of</p>		<p>the Clinical Start-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee</p>				

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	<p>Nursing on 4/18/13. She indicated the policy was current. The policy indicated, "... Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock ... Medication storage areas are kept clean, well lit, and free of clutter ..."</p> <p>3.1-25 (o)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>A. Based on observation, record review, and interview, the facility failed to ensure topical creams, ointments and powders were</p>	F000431	Step One:A. All creams, ointments, and powders that were found without labels were disposed per policy.B. RN #3 was educated on the policy for	05/18/2013			

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	<p>disposed or labeled on 1 of 3 units. This had the potential to affect 51 residents who resided on the unit (Rainbow). The facility also failed to ensure topical creams, ointments, and powders were disposed or labeled on 1 of 3 units. This had the potential to affect 35 residents who reside on the unit (Memory).</p> <p>B. Based on observation, record review and interview, the facility failed to ensure a transdermal patch was disposed per policy and failed to ensure a vial of insulin had a label indicating medication change for 1 of 9 residents observed during medication pass.</p> <p>Findings included:</p> <p>A1. Observation of the medication storage room on Rainbow Lane was completed on 4/17/13 at 1:20 p.m. The following creams, ointments, and powders were observed opened and unlabeled:</p> <ol style="list-style-type: none"> <li>Two Nystatin topical powders</li> <li>Four Vasolex ointments</li> <li>Four Santyl ointments</li> <li>Lidocaine ointment with a label where the info had faded away/no new label</li> <li>Two tubes of bacitracin ointment</li> </ol>		<p>disposal of a Fentanyl Patch. A Direction Change Label was placed on the bottle of insulin for Resident #119. Step Two: A. All medication storage areas were inspected to ensure that all creams, ointments, and powders were appropriately labeled. No other deficiencies were noted. B. The DNS conducted Med Pass Observations to visualize disposal of Fentanyl Patches. The DNS visualized all insulin bottles to ensure current directions were listed on the label. Any deficiencies noted were corrected. Step Three: A. All Licensed Nurses were re-educated on the Medication Storage and Medication Label Policies. The DNS and/or designee will inspect all medication storage areas two times weekly to ensure that all medications are appropriately labeled and are not outdated, contaminated, or deteriorated. The DNS will report any trends or findings to the QAPI Committee monthly. B. All Licensed Nurses were educated on the policy for disposal of Fentanyl Patches requiring two nurses signatures for disposal. The DNS and/or designee will visually observe the medication disposal log of all residents receiving Fentanyl Patches weekly to ensure appropriate documentation of disposal. The DNS will report any trends or findings to the QAPI Committee monthly. All Licensed</p>		

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	<p>f. Diaper rash cream g. Two Clotrimazole creams h. Metronidazole cream i. Nystatin cream</p> <p>During this time, the Assistant Director of Nursing Services acknowledged the items without labels and indicated the cabinets needed to be cleaned out.</p> <p>A2. Observation of the medication storage room on Memory Lane was completed on 4/17/13 at 2:30 p.m. The following creams, ointments, and powders were observed opened, unlabeled or expired:</p> <p>a. Bactroban ointment b. Nystatin cream c. Bacitracin ointment d. Vasolex ointment label was worn off. e. Two iodoform packing strip unopened but expired on 3/2013. f. Arglaes powder (expired on 11/2012).</p> <p>During this time, the Unit Manager acknowledged the items and removed them from drawers and cabinets.</p> <p>B. RN #3 was observed on 4/15/13 at 8:40 a.m., removing a fentanyl patch from Resident #119. She</p>		<p>Nurses were re-educated regarding the policy for Medication Label and use of direction change labels. The DNS and/or designee will visually inspect all insulin bottles for appropriate labeling two times weekly. The DNS will report trends or findings to the QAPI Committee monthly. Step Four: The results of the medication storage, medication disposal logs, and insulin bottle audits will be reviewed two times weekly during the Clinical Start-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee</p>				

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	<p>wrapped it in a glove then discarded the patch in the sharps container. RN #3 was also observed drawing up 38 Units of insulin in a syringe. The label on the insulin bottle indicated 20 Units of insulin to be given at bedtime. Interview with RN #3 during this time, indicated the fentanyl patch was to be discarded in the sharps container and the physician changed the amount of insulin to be given, as well as the time of day due to the resident's fluctuating blood sugars. RN #3 placed a sticker on the bottle indicating a change in directions.</p> <p>A Disposal of Medication, Syringes and Needles policy dated 10/07, was provided by the Director of Nursing on 4/18/13 at 8:00 a.m. The policy indicated "... For the State of Indiana, these non-controlled medications shall be disposed of by the nursing care center in the presence of appropriately titled professionals: Two licensed nurses, Licensed nurse and a pharmacist, or QMA (Qualified Medication Administrator) and a licensed nurse."</p> <p>A Medication Storage policy dated 09/08, was provided by the Director of Nursing on 4/18/13 at 8:00 a.m. The policy indicated "... Outdated, contaminated, discontinued or</p>						

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	<p>deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists."</p> <p>A Medication Label policy dated 10/07, was provided by the Director of Nursing on 4/18/13 at 8:00 a.m. The policy indicated "Medications are labeled in accordance with currently accepted professional principles including appropriate auxiliary and cautionary instructions to promote safe medication use following state and federal laws ... If the prescriber's directions for use change or the label is inaccurate, the nurse may place a 'direction change', 'change of order-check chart', or similar label on the container indicating there is a change in directions for use, taking care not to cover important label information ... Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the dispensing pharmacy for re-labeling or destroyed in accordance with the medication destruction policy ... The manufacturer's or pharmacy's label shall include the following:</p>			

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	<p>medication name, medication strength, quantity, accessory information, lot number and expiration date ..."</p> <p>3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7) 3.1-25(l)(1) 3.1-25(l)(2) 3.1-25(l)(3) 3.1-25(l)(4) 3.1-25(l)(5) 3.1-25(o)</p>			

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F000441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	Step One:1. CNA #1 was re-educated	05/18/2013			

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	<p>maintain a sanitary and comfortable environment related to improper storage of a bedpan and urinal in shared resident bathrooms. The facility also failed to ensure proper hand washing was completed after glove removal and/or direct resident contact for 1 of 3 treatments observed and during medication administration. The facility also failed to ensure the glucometer was disinfected after use for 2 of 2 glucometers observed, and isolation precautions were followed for 1 of 3 residents observed in isolation. (Residents #25, #109, #119, #83, #133, and #138) (Rooms 4, 7, 12, 13, 15, 16, 23, 127, and 216)</p> <p>Findings include:</p> <p>1. On 4/17/13 at 9:09 a.m., the pressure ulcer treatment for Resident #25 was observed. CNA #1 put on a pair of gloves and helped with positioning the resident. When the treatment was completed, the CNA removed her gloves and walked out of the resident's room. The CNA was not observed to wash her hands or use a hand sanitizer prior to leaving the room.</p> <p>Interview with RN #5 on 4/18/13 at 9:30 a.m., indicated the CNA should have washed her hands after</p>		<p>on Handwashing/Hand Hygiene Policy during resident care and after glove removal prior to leaving the room.2. To include A-1: all bedpans, urinals, foley catheter bags, and raise toilet seats were disinfected, bagged, and stored per policy.3. RN #2 was re-educated on the Handwashing/Hand Hygiene Policy during medication pass and after resident contact.4. RN #2 was re-educated on the Hand Hygiene Policy, Glucometer Cleaning Policy, and the procedure of proper handling of the glucometer while in resident room. The glucometer, and medication cart were cleaned per policy.5. RN #3 was re-educated on the Hand Hygiene Policy and the Cleaning and Disinfection of Resident are Items and Equipment Policy. RN #3 cleaned the stethoscope per policy.6. RN #1 was re-educatd on the Cleaning and Disinfection of Residnt Care Items and Equipment. The stethoscope, pulse oximeter, and medication cart were cleaned per policy.7. RN #1 was re-educated on the Glucometer Cleaning Policy an the Cleaning and Disinfection of Resident Care Items and Equipment. The glucometer, bottom surface of basket, and medication cart were cleaning per policy.8. RN #1 was re-educated on the Isolation Policy, Handwashing/Hand Hygiene Policy, and the Cleaning</p>				

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	removing her gloves prior to leaving the room.		and Disinfection of Resident Care Items or Equipment. The stethoscope, pulse oximeter, clipboard, and medication cart were cleaned per policy. Step Two: The DNS completed infection control rounds to observe for proper handwashing, cleaning of glucometers, cleaning of equipment, isolation procedures, cleaning/storage of bedpans, urinals, Foley catheter bags, and raised toilet seats. Any deficiencies noted were corrected. Step Three: All nursing staff were re-educated on the Handwashing/Hand Hygiene Policy, Cleaning and Disinfection of Resident Care Items and Equipment Policy, Glucometer Cleaning Policy, and Bedpan and Urinal Storage Policy. The DNS and/or designee will conduct infection control rounds three times weekly on all units and all shifts to ensure proper infection control practices are in place. The DNS will report any trends or findings to the QAPI Committee monthly. Step Four: The results of the infection control rounds will be reviewed three times weekly during the Clinical Start-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will		

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	<p>2. On 4/17/13 at 10:40 a.m., during the environmental tour the following was observed on the Rainbow, Terrace and Memory Units:</p> <p>A. In room 12 an urinal was observed on top of bedside shelf uncovered and tilted over. There was one resident who resided in this room.</p> <p>B. In room 15 a bedpan and an urinal were observed in the bathroom and uncovered. There were two residents who resided in this room.</p> <p>C. In room 7 there were two urinals hanging from the grab bar in the bathroom next to the toilet. There was also a bedpan on the closet shelf that was uncovered. There was one resident who resided in this room.</p> <p>D. In room 16 there was an urinal observed on the grab bar in bathroom and bedpan on back of the commode. Both were uncovered. There were two residents who resided in this room.</p> <p>E. In room 23 there was a bedpan observed on the floor in the</p>		be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee				

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	<p>bathroom. The bedpan was not in a plastic bag. There were two residents who resided in this room.</p> <p>F. In room 4 there was a foley catheter leg bag on the floor in the closet. The leg bag was not in a plastic bag. There was also a bedpan on the floor in the closet and not in a plastic bag. There was one resident who resided in this room.</p> <p>G. In room 13 there were three urinals on the bedside table. All three urinals were uncovered. There was one resident who resided in this room.</p> <p>H. In room 216 there was a raised toilet seat observed uncovered and on the floor. There were two residents who resided in this room.</p> <p>I. In room 127 there was a bath basin observed on the floor in the bathroom. The basin was not in a plastic bag. There were two residents who resided in this room.</p> <p>Review of the current and undated Bedpan and Urinal Storage Policy provided by the Administrator on 4/18/13, indicated "All bedpans and urinals will be marked with residents room number and bed number then</p>						

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	<p>placed in a plastic bag and stored in the drawer of the bed side night stand."</p> <p>Interview with the Administrator on 4/17/13 at 11:30 a.m., indicated the urinals, bedpans, and bath basins should all be covered with a plastic bag and stored in the resident's closet.</p> <p>3. On 4/15/13 at 5:20 a.m., RN #2 was observed administering medication to a resident. She touched the resident after administration. RN #2 did not wash or sanitize her hands prior to the next medication administration.</p> <p>4. On 4/15/13 at 5:30 a.m., RN #2 was observed obtaining a blood sugar on Resident #109. The accu check machine was observed on the medication cart without a barrier, taken into the resident's room and placed on her night stand without a barrier. RN #2 applied gloves prior to the accu check. The accu check strip was removed from the machine and wrapped into the gloves. RN#2 went into the bathroom to wet a wash cloth and cleaned the resident's face. RN #2 placed the soiled wash cloth into the dirty linen cart and then opened</p>				

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	<p>the medication cart to place the accu check machine into the drawer lying on top of the finger sticks.</p> <p>Interview with RN #2 during this time, indicated she was to clean the accu check machine with alcohol after every patient and acknowledged she did not clean the machine. RN #2 also indicated she was to wash her hands between residents and after removing her gloves.</p> <p>5. On 4/15/13 at 8:40 a.m., RN #3 was observed with Resident #119 during medication pass. RN #3 entered the resident's room and washed her hands for 5 seconds. RN #3 applied gloves then she applied a nitro patch to the resident's chest wall. RN #3 entered the bathroom and washed her hands for 5 seconds. RN #3 returned to the medication cart, retrieved the fentanyl (pain) patch, wrote in the narcotic book, applied gloves, then applied the fentanyl patch. RN #3 then removed her gloves, used hand sanitizer, re-gloved, removed the fentanyl patch and wrapped in it in the glove and put it into the sharps container. RN #3 returned to the bathroom and washed her hands for 5 seconds again. RN #3 then used hand sanitizer, gloved, gave Resident #119 her insulin,</p>			

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	<p>placed the syringe in the sharps container, removed gloves, and washed her hands for 5 seconds. RN #3 applied gloves again, used her stethoscope that was around neck (there was a disposable stethoscope hanging on the feeding pole) obtained the resident's blood pressure, then placed the stethoscope back around her neck. RN #3 removed her gloves, washed her hands for 5 seconds, cleaned the bell of the stethoscope with an alcohol pad, sanitized her hands, and began to prepare the resident's gastronomy medications. RN #3 used her own stethoscope to verify placement on the resident's abdomen. RN #3 removed her gloves and returned to the medication cart. Interview with RN #3 during this time, indicated hand washing should be 1 minute or to sing happy birthday and she should have cleaned the stethoscope before placing it around the neck.</p> <p>6. On 4/17/13 at 4:05 p.m., RN #1 was observed providing Resident #83 with her breathing treatment. RN #1 was observed to have assessed the resident's lungs and heart with her own stethoscope, placed the pulse oximeter on the bedside table, placed the probe on the resident's finger, and replaced the stethoscope back</p>						

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	<p>around her neck. RN #1 placed the pulse oximeter on top of the medication cart and did not clean the pulse oximeter or her stethoscope.</p> <p>7. On 4/17/13 at 4:40 p.m., RN #1 was observed to utilize the accu check machine on Resident #138. RN #1 placed the accu check on the resident's bedside table as well as the basket of finger sticks without barriers. After the accu check, RN #1 returned the basket of finger sticks and accu check machine to the medication cart and placed it back into the drawer without cleaning the machine or the bottom surface of the basket.</p> <p>8. On 4/17/13 at 4:50 p.m., RN #1 was observed going into Resident #133's room without PPE (personal protective equipment) and with her clip board and pulse oximeter. RN #1 placed the clip board and pulse oximeter on a bed in the resident's room. The resident did not have a mask over her trach. RN #1 utilized her own stethoscope to assess the resident's lungs then replaced the stethoscope back around her neck. RN #1 returned to the medication cart without washing her hands, and placed the pulse oximeter back on the medication cart without cleaning it.</p>			

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	<p>Resident #133 had a red contact isolation sign on the door which indicated to wear a gown, gloves, mask and to use disposable PPE equipment or clean PPE after use. An interview with RN #1 during this time, indicated she felt that being so far away from a resident was sufficient. An interview with the Unit Manager indicated the resident's MRSA was colonized and she didn't feel the resident needed to be in isolation but the pulmonologist was in the hospital and his office told her she would have to wait on the physician returning to work in regards to isolation precautions.</p> <p>Resident #133's record was reviewed on 4/18/13 at 9:30 a.m. A Physician progress note dated 4/3/13, indicated the resident had chronic MRSA at her tracheal site and doxycycline (antibiotic) had been continued for treatment. The April 2013 Physician orders indicated the resident was to be in contact precautions daily every shift. The resident was to have her trach covered by mask when she was out of the room daily.</p> <p>An undated Step by Step test procedure for glucometers was provided by the Director of Nursing on</p>				

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	<p>4/18/13 at 8:00 a.m. The Step by Step test procedure indicated to place the accu check machine on a barrier before setting the unit on resident equipment and to wash hands after use. The procedure also indicated the meter exterior was to be cleaned after each resident use with 10% bleach wipes and allowed to air dry.</p> <p>Glucometer cleaning: Meter exterior is cleaned after each resident use with 10% bleach wipes. Do not spray any cleaning solution on the meter. Never use a spray of any type. With the meter turned off, wipe the meter's exterior clean with the 10% bleach wipe. With a lint free tissue, dry the meter or allow to air dry.</p> <p>The Clorox bleach germicidal wipes label was provided on 4/18/13 at 8:00 a.m. by the Director of Nursing (DoN). The label indicated for MRSA (Methicillin resistant staphylococcus aureus), "...to clean and disinfect...wipe hard, nonporous surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for the contact time listed on label (30 sec). Let air dry..."</p> <p>A policy for Cleaning and Disinfection of Resident care items and equipment dated 10/2009, was provided by the</p>				

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	<p>DoN on 4/18/13 at 8:00 a.m. The policy indicated "...reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions."</p> <p>A policy for Isolation dated 8/2012, was provided by the DoN on 4/18/13 at 8:00 a.m. The policy indicated "...In addition to wearing gloves as outlined under Standard Precautions, wear gloves when entering the room. While caring for a resident, change gloves after having contact with infective material. Remove gloves before leaving room and perform hand hygiene. After removing gloves and washing hands, do not touch potentially contaminated environment surfaces or items in the resident's room. Wear a disposable gown upon entering the Contact Precautions room or cubicle. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces...When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer (blood pressure cuff), bedside commode, or electronic thermometer to a single resident to avoid sharing between residents. If use of common items is unavoidable,</p>			

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	<p>then adequately clean and disinfect them before use for another resident.</p> <p>A policy for Handwashing/hand hygiene dated 10/2011, was provided by the DoN on 4/18/13 at 8:00 a.m. The policy indicated "...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...before and after direct resident contact, before and after performing any invasive procedure (e.g., finger stick blood sampling), before and after entering isolation precaution settings...before and after changing a dressing, upon and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident...after removing gloves or aprons...If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol...hand hygiene is always the final step after removing and disposing of personal protective equipment..."</p> <p>3.1-18(j) 3.1-18(l)</p>				

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F000463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, and interview, the facility failed to ensure each resident's call system was functional related to the emergency call light in the bathroom of room 25.</p> <p>Findings include:</p> <p>On 4/12/13 at 8:09 a.m., the emergency call light in the bathroom of room 25 was not functioning. There were three residents who resided in the room.</p> <p>Interview on 4/12/13 at 8:09 a.m., with Maintenance staff #1, indicated the call light in the bathroom was not functioning and needed to be repaired.</p> <p>Interview with the Rainbow Unit Manager on 4/12/13 at 8:17 a.m., indicated the residents who resided in the room used the call light in the bathroom.</p> <p>Interview with the Maintenance Director on 4/17/13 at 10:40 a.m., indicated the call system was not</p>	F000463	<p>Step One: The call light was replaced on 4/12/13 Step Two: All call lights were checked on 4/12/13 and all were found in good operating condition.. Step Three: A review of the Preventative Maintenance Log reveals that call light audits were performed monthly as scheduled. The Maintenance Director or designee will audit three call lights on each nursing unit times weekly for One month then all call lights monthly to ensure proper operation. The Maintenance Director will report any trends or findings to the QAPI Committee monthly. Step Four: The results of the call light audit will be reviewed three times weekly during the Stand-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee</p>	05/18/2013			

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	functioning on 4/12/13.  3.1-19(U)(2)				

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred walls, broken and dirty window sills, chipped floor tile, dirty wheelchairs, stained floor tile, and torn base board for 3 of 3 units. The facility also failed to ensure the kitchen was in good repair related to stained and discolored rolling carts and dish racks. This had the potential to effect 129 residents who resided in the facility. (The Rainbow, Memory, and Terrace Units and the Main Kitchen)</p> <p>Findings include:</p> <p>1. On 4/17/13 at 10:30 a.m., during the Environmental Tour the following was observed on the Rainbow Unit:</p> <p>A. In room 12 there was chipped floor tile under the bed and the window sill was dirty. There was one resident who resided in this room.</p> <p>B. In room 15 there were broken floor tiles observed in the bathroom. There were two residents who resided in this</p>	F000465	<p>Step One:All issues identified within the survey were corrected.Step Two:An environmental audit was conducted and any environmental concerns were addressed. Step Three:All nursing staff were re-educated regarding the wheelchair cleaning schedule. Housekeeping and Maintenance staff were re-educated regarding cleaning and maintenance schedules and processes. The Executive Director and/or designee will conduct Environmental rounds three times weekly for one month to ensure that resident dignity is maintained at all times. The Director will report any trends or findings to the QAPI Committee monthly.Step Four:The results of the environmental rounds will be reviewed three times weekly during the Stand-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will be considered a trend or</p>	05/18/2013			

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	<p>room.</p> <p>C. In room 22 the wall was marred behind the chair and the bathroom floor was stained under the toilet. There were two residents who resided in this room.</p> <p>2. On 4/17/13 at 11:00 a.m., during the Environmental Tour the following was observed on the Memory Unit:</p> <p>A. In room 212 the wood portion of the window sill was cracked and not adhered to the frame. The walls were marred by the bed. There were two residents who resided in this room.</p> <p>B. In Room 205 the floor under the toilet was stained and the walls by the bed and on the inside of the door were marred. There was one resident who resided in this room.</p> <p>C. In room 223 the resident's wheelchair was dirty with a large amount of crumbs noted under the seat cushion. There was also a six inch piece of base board pulling away from the wall behind the resident's bed. There were two residents who resided in this room.</p> <p>D. In room 222 the wood portion of the window sill was cracked and not</p>		<p>pattern), the results will be reviewed quarterly by the QAPI Committee</p>		

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	<p>adhered to the frame. There were two residents who resided in this room.</p> <p>E. In Room 211 the caulking around the window was cracked and peeling away. There was one resident who resided in the room</p> <p>3. On 4/17/13 at 11:10 a.m., during the Environmental Tour the following was observed on the Terrace Villa Unit:</p> <p>A. The microwave and toaster were dirty. The toaster handles had a dried sticky substance on them and inside the microwave was dirty with dried food substance. There was also a large number crumbs noted on the table and on the tray they were placed on.</p> <p>Interview with the Maintenance Supervisor at the time, indicated all the above was in need of cleaning and/or repair.</p> <p>4. During the Kitchen Sanitation Tour on 4/18/13 at 9:46 a.m., with the Dietary Food Manager, the following was observed:</p> <p>a. Six plastic dish racks used to run dishes through the dishwasher were faded, marred and discolored with</p>			

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	<p>lime build up.</p> <p>b. Two plastic rolling carts located in the dish room were stained and discolored.</p> <p>Interview with the Dietary Food Manager at the time, indicated the facility was in need of new dish racks and carts.</p> <p>Interview with the Administrator on 4/18/13 at 10:00 a.m., indicated the dish racks needed to be replaced.</p> <p>3.1-19(f)</p>				

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F000503 SS=D	<p>483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT</p> <p>If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.</p> <p>If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter.</p> <p>If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.</p> <p>If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.</p> <p>Based on observation, record review, and interview, the facility failed to ensure expired lab testing supplies were properly disposed for 1 of 3 units. This had the potential to affect 35 residents who resided on the unit. (Memory Lane).</p> <p>Findings included:</p> <p>1. Observation of the medication storage room on Memory Lane was completed on 4/17/13 at 2:30 p.m. The following supplies were observed</p>	F000503	<p>Step One:All expired laboratory supplies including the blood draw kits, blood occult cartridges, and fecal transport systems were disposed.Step Two:All laboratory supply storage areas were inspected to ensure that all supplies are within the expiration date. No other deficiencies were noted.Step Three:All Licensed Nurses were re-educated on the F503 requirement to ensure that all expired laboratory testing supplies are disposed of properly. The DNS and/or designee will inspect all laboratory supply areas</p>	05/18/2013	

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	<p>expired:</p> <p>a. 8 Blood draw kits (three expired on 9/30/12, two expired on 7/31/11, and three expired on 1/31/13).</p> <p>b. 40 blood occult cartridges (expired on 11/12).</p> <p>c. 11 fecal transport system (expired on 12/27/12).</p> <p>During this time, the Unit Manager acknowledged the items and removed them from drawers and cabinets.</p> <p>3.1-49(a)</p>		<p>two times weekly to ensure that all expired laboratory testing supplies are disposed. The DNS will report any trends or findings to the QAPI Committee monthly. Step Four: The results of the laboratory supply audit will be reviewed two times weekly during the Clinical Start-Up Meeting and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months to determine the need for any further change to the plan of correction. If after six months of review without any trends or patterns noted (3 deficient practices per month will be considered a trend or pattern), the results will be reviewed quarterly by the QAPI Committee</p>		