

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2012
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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 17, 2012.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00105961 completed on March 23, 2012.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00106286.</p> <p>Survey dates: April 11, 12, and 13, 2012</p> <p>Facility number: 010996 Provider number: 155665 AIM number 200232210</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 102 Total: 102</p> <p>Census payor type: Medicare: 12 Medicaid: 84 Other: 6 Total: 102</p>	F0000		

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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	<p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/20/12 by Suzanne Williams, RN</p>				

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure it was free from a medication error rate of greater than 5% during 2 of 3 medication pass observations in which 3 medication administration errors occurred in 55 medication administrations, which yielded an error rate of 5.4%. This affected 2 of 9 residents observed during medication pass (Residents #70 and #8).</p> <p>Findings include:</p> <p>1. During a medication pass observation on 4-12-12 from 4:25 p.m. to 4:45 p.m. with LPN #1 with Resident #70, she was observed to obtain a bottle of Humalog Insulin, 100 units per milliliter (100 units/ml) strength for Resident #70. She was observed to draw up 22 units of the insulin into a standard insulin syringe for administration. She indicated, "I always worry about air bubbles, so I get a little extra and then push it [the extra amount] out." When the incorrect dosing was pointed out to LPN #1, she then obtained the correct dose prior to administration.</p> <p>In review of Resident #70's clinical record</p>	F0332	<p>F332 FREE OF MEDICATION ERROR RATE OF 5% OR MORE Criteria #1 A. LPN #1 was re-educated on the procedure for insulin injection. Resident # 70 received the correct insulin per physician's orders. B. LPN #2 was re-educated on the procedure for verifying the correct medication, at the correct dose, at the correct route, at the correct time, for the correct resident. There was no negative outcome to Resident #8. Criteria #2 A. All residents receiving medication have the potential to be affected by inaccurate administration. Criteria #3 A. Licensed staff were re-educated by the DCS (Director of Clinical Services)/ADCS (Assistant Director of Clinical Services) on medication administration. B. DCS (Director of Clinical Services)/ADCS (Assistant Director of Clinical Services) will randomly QI monitor medication administration 4 times daily 5 times per week, then 4 times daily for 3 weeks then weekly ongoing. C. Any negative findings will be addressed with Coaching Plans and re-education. Criteria #4 A. Findings will be brought to the RM/QI for review and development of an action plan to</p>	05/01/2012
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	<p>on 4-13-12 at 2:07 p.m., the April 2012 recapitulation orders indicated he was to receive Humalog Insulin (100 units/ml) 20 units subcutaneously [under the skin] three times daily with meals.</p> <p>Immediately after LPN #1 completed the above medication preparation, she was observed to obtain a bottle of Humulin N Insulin, 100 units/ml strength for Resident #70. She was observed to draw up 32 units of the insulin into a standard insulin syringe for administration. When the incorrect dosing was pointed out to LPN #1, she indicated, "I guess I looked at the order wrong." She then obtained the correct dose of insulin prior to administration.</p> <p>Review of Resident #70's April 2012 recapitulation orders indicated he was to receive Humulin N (100 units/ml) 34 units subcutaneously every evening for diabetes.</p> <p>2. During a medication pass observation with LPN #2 for Resident #8 on 4-13-12 between 8:40 a.m. and 8:48 a.m., she was observed to obtain a bottle of medication labeled as "Senna S" for Resident #8. This bottle indicated the medication was a combination product of docusate sodium 50 milligrams (mg) and senna 8.6 mg. LPN #2 was observed to administer one</p>		ensure medication is administered per physicians order. Criteria #5 5/1//2012				

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	<p>tablet of this medication Resident #8, along with the resident's other morning medicines.</p> <p>In review of Resident 8's clinical record on 4-13-12 at 2:21 p.m., the April 2012 recapitulation orders indicated the resident was to receive senna 8.6 mg twice daily by mouth. There was not an order for "Senna S" documented.</p> <p>The Administrator provided a policy on 4-12-12 at 8:45 a.m., entitled, "General Dose Preparation and Medication Administration." This policy had a revision date indicated as 5-1-10 and was indicated to be the current policy for the facility. This policy indicated, "Facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..."</p> <p>3.1-25(b)(9) 3.1-48(a)(3)</p>				

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure the correct labeling of over the counter medications included the physician's name on the</p>	F0431	F431 S/S D DRUG RECORDS, LABEL/STORE DRUGS&BIOLOGICALS Criteria #1 A. LPN #2 was re-educated on correct labeling of over the	05/01/2012			

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	<p>bottle for 1 medication each for 3 of 9 residents observed during 1 of 3 medication pass observations. (Residents #8, #11, and #23)</p> <p>Findings include:</p> <p>1. During a medication pass on 4-13-12 between 8:40 a.m. and 9:30 a.m. with LPN #2 for Resident #8, she was observed to obtain a bottle of Senna S from the medication cart. This bottle of medication was observed to have no physician's name on the it.</p> <p>2. During a medication pass on 4-13-12 between 8:40 a.m. and 9:30 a.m. with LPN #2 for Resident #11 she was observed to obtain a bottle of Thera Tab M from the medication cart. This bottle of medication was observed to have no physician's name on the it.</p> <p>3. During a medication pass on 4-13-12 between 8:40 a.m. and 9:30 a.m. with LPN #2 for Resident #23, she was observed to obtain a bottle of Oyster Shell Calcium 500 milligrams plus Vitamin D-3 200 international units from the medication cart. This bottle of medication was observed to have no physician's name on the it.</p> <p>In an interview on 4-13-12 at 8:41 a.m.</p>		<p>counter medications to include physician's name. B. There was no negative outcome. Criteria #2 All residents have the potential to be affected by inaccurate labeling. Criteria #3 A. All licensed staff will be re- educated by the Regional Clinical Consultant on correct labeling of Over the Counter Medications. B. DCS (Director of Clinical Services)/ADCS (Assistant Director of Clinical Services) will QI monitor All Over the Counter Medications for correct labeling five times a week for one month and then monthly for three months to assure compliance. C. Negative findings will be addressed with Coaching Plans and re-education. Criteria #4 Results of the audits will be reviewed in the monthly RM/QI Meeting to assure continued compliance. Criteria #5 5/1/2012</p>				

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	<p>with LPN #2, she indicated, "The pharmacy tells us we are not to be writing anything on the label."</p> <p>This deficiency was cited on 2/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25(j) 3.1-25(l)(2)</p>			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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, interview and record review, the facility failed to ensure</p>	F0441	F441 S/S =D INFECTION CONTROL, PREVENT	05/01/2012			

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	<p>facility staff properly disinfected glucometers between residents during 2 of 2 observations of glucometer use for 2 of 2 residents. During 2 of 2 observations of glucometer use, 2 of 2 staff observed indicated they were unsure of the facility's policy on disinfection of the glucometers. (Residents #70 and #77, LPN #1, and LPN #3)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 4-11-12 between 4:03 p.m. and 4:39 p.m. with LPN #3 for Resident #77, she was observed to use a glucometer to check the blood sugar readings on Resident #77. After obtaining the blood sugar reading with the glucometer, she was observed to place the glucometer on top of the medication cart. When queried as to how the glucometers are cleaned and when, she indicated, "The machine is cleaned after each use with a bleach wipe or alcohol wipe and then let air dry." She was then observed to obtain an alcohol wipe and to clean the glucometer. She indicated her medication cart was not stocked with the bleach wipes. She indicated she would have to check the facility's policy to see what it said in regard to cleaning the glucometer. At 4:24 p.m., she obtained a container of bleach wipes and cleaned the machine</p>		<p>SPREAD,LINENS</p> <p>Criteria #1</p> <p>A. Licensed Nurse #3 and licensed Nurse #1 were educated on the Policy for cleaning glucometer units between uses. No residents were affected as corrective action was immediately taken.</p> <p>Criteria #2</p> <p>No instances of failure to follow policy for glucometer cleaning between uses were identified.</p> <p>Criteria #3</p> <p>A. All licensed Nurses will be re-educated by the Regional Clinical Consultant on the policy for cleaning glucometer units between uses. Education will include appropriate cleansing agents to be utilized between resident uses.</p> <p>B. DCS (Director of Clinical Services)/Designee will monitor glucometer use five times weekly for one month and then monthly for three months to assure compliance.</p> <p>Criteria #4</p> <p>Results of the audit will be reviewed in the monthly RM/QI Meeting to assure continued compliance.</p> <p>Criteria #5</p> <p>5/1/2012</p>				

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	<p>with the bleach wipe.</p> <p>2. During a medication pass observation on 4-12-12 between 4:25 p.m. and 4:45 p.m. with LPN #1 for Resident #70, she was observed to use the glucometer to check the blood sugar readings on Resident #70. After obtaining the blood sugar reading with the glucometer, she was observed to place the glucometer on top of the medication cart. When queried as to how the glucometers are cleaned and when, she indicated, "I think [disinfection is conducted] between residents...with alcohol, don't really know. I think [name of staff member] cleans them and checks them each night." After checking with another staff member, she returned to the medication cart with the staff member. The other staff member indicated to LPN #1 the location of the bleach wipes on the medication cart. At this time, LPN #1 then disinfected the glucometer with the bleach wipe.</p> <p>On 4-13-12 at 4:00 p.m., the Assistant Director of Nursing provided a copy of the "Orientation Education/In-Service Record" for LPN #1, dated 7-12-11 and 7-13-11, and for LPN #3, dated 1-25-12. Each record indicated the cited dates as dates of completion for the topics of "Infection Prevention & Control" and for "OSHA/Blood Borne Pathogens/Hepatitis</p>			
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	<p>C."</p> <p>On 4-13-12 at 10:30 a.m., the Administrator provided a copy of a procedure entitled, "Blood Glucose Testing." This procedure indicated a revision date of 12/09 and was indicated to be the facility's current procedure in use. This procedure indicated, "Disinfect the blood glucose monitor after each use with 1:10 dilution of sodium hypochlorite (bleach) unless the manufacturer recommendations say otherwise. Note: Do not use alcohol to disinfect the monitor."</p> <p>This deficiency was cited on 2/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-18(b)</p>				