

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155199	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2013
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NAME OF PROVIDER OR SUPPLIER  MAPLE PARK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: May 6, 7, 8, 9, 10, 13, and 14, 2013</p> <p>Facility number: 000106 Provider number: 155199 AIM number: 100266390</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N.</p> <p>Census bed type: SNF--8 SNF/NF--90 Total--98</p> <p>Census payor type: Medicare--6 Medicaid--82 Other--10 Total--98</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review was completed by Tammy Alley RN on May 21, 2013.</p>	F000000		

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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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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 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 ensure a bath tub was available for 2 residents who desired to have a tub bath, in a sample of 5 residents reviewed for choices and preferences that were important to them. (Residents #42 and #110)</p> <p>Findings include:</p> <p>1. In an interview on 5/07/2013 at 1:34 P.M., Resident #42 indicated she would like to have a tub bath instead of a shower, but one was not offered.</p> <p>The clinical record was reviewed on 5/9/13 at 10:28 A.M. Diagnoses included, but were not limited to, schizophrenia, senile dementia, diabetes, legal blindness, and osteoarthritis.</p> <p>A Significant Change MDS (Minimum Data Set) assessment, dated 7/11/12,</p>	F000242	<p>F 242</p> <p>#1: In regards to Residents #42 and #110, the facility has contracted to have a new tub installed in the facility for resident use. Both resident #42 and #110 were interviewed and stated that they find the bathing method of a shower to be acceptable as a reasonable accommodation until a tub is available.</p> <p>#2 All residents that have a preference of a tub bath have the potential to be affected. All residents will be interviewed regarding their bathing preference. Residents that request a tub bath will be provided with reasonable alternative bathing accommodations until the completion of the installation of a tub. Once tub bath is installed, residents will be informed by ED/designee of the availability of the tub bath to ensure that residents are provided a choice. Care plan and CNA assignment</p>	06/07/2013			

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	<p>indicated in Section F that it was "Very Important" to her to choose between a tub bath, a shower, and a bed bath.</p> <p>The "RESIDENT CARE/NEED SHEET", identified by the interim Director of Nursing as a communication sheet for the CNAs and updated daily, indicated Resident #42 was assigned "Shower Day &amp; Shift: Tuesday-Friday, evenings." There was no documentation of the resident's preference for a tub bath.</p> <p>2. In an interview on 5/07/2013 at 1:47 P.M., Resident #110 indicated she would like to take a tub bath, but one was not offered because there was no tub in the facility.</p> <p>The clinical record was reviewed on 5/9/13 at 2:30 P.M. Diagnoses included, but were not limited to, diabetes, hypertension, schizophrenia, and dementia.</p> <p>The "RESIDENT CARE/NEED SHEET", identified by the interim Director of Nursing as a communication sheet for the CNAs and updated daily, indicated Resident #110 was assigned "Shower Day &amp; Shift: Tuesday-Friday, evenings." There was no documentation of the</p>		<p>sheets will be updated accordingly.</p> <p>#3 A tub will be installed in the facility to ensure that all residents have access to a tub bath if preferred. All residents will be provided with reasonable alternative bathing accommodations until a tub is installed. Residents will be interviewed upon admission to ensure that a bathing preference is identified and provided accordingly. An in-service will be provided by the ED/designee on 6.07.2013 to the IDT team in regards to assuring that bathing preference is identified of each resident and that this information is placed on the CNA assignment sheets as applicable. The resident council will be educated on the right to choose a tub by 6.07.2013. The resident council will be informed as to the plan of corrections involving the installation of a tub as well as the date of completion.</p> <p>#4 To ensure compliance, the ED/Designee is responsible for the completion of the bathing preference CQI audit tool daily x 4 weeks, weekly x 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>				

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	<p>resident's preference for a tub bath.</p> <p>3. In an interview on 5/8/13 at 9:43 A.M., LPN #4 indicated all of the rooms on the Moving Forward unit had showers in the bathroom. She indicated there was no central shower/bath area on this unit, and did not think there were any tubs in the building.</p> <p>In an interview on 5/8/13 at 9:51 A.M., CNA #5 indicated none of the rooms on the Auguste's Cottage/locked, secure Alzheimer's unit had showers. She indicated there was no tub on this unit or in the building. The CNA indicated she would ask a resident what they wanted--a shower or tub bath, but was not sure what she would do if they chose a tub bath, since there wasn't any in building. The unit shower room was observed at that time, and there was no bath tub in the room.</p> <p>In an interview on 5/8/13 at 9:55 A.M., RN #2 indicated there were no tubs in the building, but was not sure why. She indicated that would be a question for the Executive Director. The nurse indicated residents were asked about their choice of tub bath or shower upon admission, and anything other than a shower would</p>		#5 Date of Compliance: 6/07/2013				

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	<p>be carried to the CNA assignment sheet. The unit shower room was observed at that time, and there was no bath tub in the room</p> <p>In an interview on 5/9/13 at 11:05 A.M., the Executive Director indicated they (facility staff) had asked the same question (about choice of tub bath) of the current population, but none had indicated a preference for a tub bath. He indicated he got curious and started looking in the building, and found a tub in a room being used for storage and medical records, on the 200 Hall. The room was observed at that time, and the tub appeared to be an older model that was not handicapped-accessible. Multiple boxes and equipment were piled in, on and around the tub and in the room. The Executive Director indicated there might be a special lift to use with the tub. He indicated he will empty the room of all the boxed records and other equipment, and make the room and tub usable.</p> <p>3.1-3(u)3</p>			

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F000329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></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 interview and record review, the facility failed to consistently monitor for depression symptoms, and demonstrate decision-making process for determining if a GDR (Gradual Dose Reduction) attempt was warranted, for 1 of 10 residents reviewed for unnecessary drugs. (Resident #84)</p> <p>Findings include:</p> <p>The clinical record for Resident #84</p>	F000329	<p>F 329</p> <p>#1 Resident #84 was affected by this deficient practice. A review of all current psychotropic medications for resident #84 was performed with appropriate gradual dose reductions recommended and addressed by the IDT team as deemed appropriate. A Behavior monthly summary was completed for resident #84 listing the rationale and supporting documentation for how the IDT team in conjunction with the</p>	06/07/2013			

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	<p>was reviewed on 5/9/13 at 3:08 P.M. Diagnoses included, but were not limited to, hypertension, intracranial hemorrhage, senile dementia, hypothyroidism, anemia, diabetes, depressive disorder, and anxiety state.</p> <p>The current Physician order list included orders for psychotropic medications of: (8/14/12) Lorazepam (an antianxiety medication) 0.5 mg. (milligrams) 1 tablet po (by mouth) every A.M.; (9/22/11) Bupropion/Wellbutrin (an anti-depressant medication) 150 mg. 1 tablet po daily; and (9/21/11) Citalopram/Celexa (an anti-depressant medication) 10 mg. 1 tablet po every HS (bedtime).</p> <p>An "ASC [American Senior Community] Request for Gradual Dose Reduction," dated 2/14/12, indicated the following: "Lorazepam 1 mg. every A.M. (no behaviors Nov. Dec. Jan); Citalopram 10 mg. every HS (PHQ9 score of 3 on 2/13/12); Bupropion 150 mg. every A.M. (PHQ-9 score of 3 on 2/14/12)--Most recent attempt to reduce medication resulted in return and/or worsening of resident condition." There was no documentation related to when the recent attempt at a dose reduction</p>		<p>physician determined that a gradual dose reduction should not be attempted or was clinically contraindicated as determined by the physician.</p> <p>#2 All residents that are currently prescribed antipsychotic or psychotropic medications have the potential to be affected by this deficient practice. A facility audit will be performed by the DNS/designee by 6.07.2013 to ensure that all residents who meet requirement for a gradual dose reduction have had such attempted or have appropriate documentation as to the rationale and supporting documentation for how the IDT team in conjunction with the physician determined that a gradual dose reduction should not be attempted or was clinically contraindicated as determined by the physician.</p> <p>#3 All residents that meet requirements for an attempted gradual dose reduction per consultant pharmacist direction or that have had behavioral symptoms exhibited which warrant a gradual dose reduction will have a reduction attempted or have documentation to support the IDT teams rationale for how the IDT team in conjunction with the physician determined that a gradual dose reduction should not be attempted or was clinically contraindicated as determined by the physician. The IDT team will be</p>				

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	<p>occurred. A PHQ-9 score is the number obtained after completing a "9 Item Patient Health Questionnaire" for a MDS (Minimum Data Set) assessment for mood and depression problems. Score ranges are: 1-4=minimal depression; 5-9=mild depression; 10-14=moderate depression; 15-19=moderately severe depression; and 20-27=severe depression.</p> <p>A "PRN Pharmaceutical Consultation Report," dated 8/2/12, indicated "[Resident's name] has received the following psychotropic medications since September 2011. Medications due for possible gradual dose reduction: Citalopram 10 mg. Q [every] HS; Bupropion XL 150 mg. Q A.M.; Lorazepam 1 mg. Q HS." The Pharmacist's recommendations were "Is the resident a candidate for a trial dose reduction, or is resident at lowest effective doses, perhaps a trial of decreasing Lorazepam to 0.5 mg. q HS? If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated."</p> <p>The response from the physician, which was not dated, indicated "I accept the recommendation, please implement as written." The</p>		<p>in-serviced by the Social Service Consultant on 6.07.13 regarding the procedure and policy for attempting gradual dose reductions, the completion of Behavior symptom monthly summary forms, as well as the documentation required when a dose reduction is not attempted or was clinically contraindicated as determined by the physician.</p> <p>#4 To ensure compliance, the ED/Designee is responsible for the completion of the Gradual Dose Reduction CQI audit tool bi-weekly x 4 weeks, weekly x 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>#5 Date of Compliance: 06/07/2013</p>		

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	<p>Lorazepam was decreased to 0.5 mg.</p> <p>The Citalopram and Bupropion were not addressed by the physician on the pharmacy recommendation sheet dated 8/2/12. Subsequent pharmacy recommendation reports for the anti-depressant medications were not found in the clinical record.</p> <p>An "ASC Behavior Symptom Monthly Summary Form," dated August, 2012, indicated the the following: "0 [zero] episodes anxiety." Symptoms of depression, as displayed by this resident, were not listed. The space used to indicate when the last GDR was attempted was marked "NA" [Not Applicable]. The section titled "Date of documentation from physician of clinical contraindication" was marked 2/15/12, without any accompanying documentation describing the clinical contraindication.</p> <p>There were no "ASC Behavior Symptom Monthly Summary Form" entries between August 2012 and February, 2013.</p> <p>The February, 2013 "ASC Behavior Symptom Monthly Summary Form" indicated "[Resident's name] has a diagnosis of anxiety which she may exhibit by repetitive verbalizations. 0</p>						

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	<p>[zero] episodes. Medications #1 and #2 [Bupropion and Citalopram]: Supporting Dx--Depression. Specific medication--Buproban 150 mg. qd.; Citalopram 10 mg." The section used to document the date of the last GDR was blank.</p> <p>The March, 2013 "ASC Behavior Symptom Monthly Summary Form" listed the same information as the February form. The section to document the number of episodes of anxiety was blank. The same medications and dosages were listed. The form indicated "No recommended changes per BX [Behavior] team on 4/9/13" There was no other information describing how the team determined a GDR should not be attempted, or was clinically contraindicated as determined by the physician.</p> <p>Social Service progress notes indicated the following: 10/11/12--"PHQ-9 score 8/27, suggesting mild depression. Has recently been ill with pneumonia." 12/24/12--"PHQ-9 score 7/27...." 3/17/13--"PHQ-9 score 10/27. Has been spending a lot of time in room lately due to recent infection and not feeling well. Daughter visits frequently. She and roommate get</p>						

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	<p>along."</p> <p>In an interview on 5/10/13 at 10:01 A.M., the Social Service Director indicated she had been in the facility since October, 2012. She indicated she had started the "Behavior monitoring" forms in February when she realized they were not being completed. The "Behavior" team waited until the second Tuesday of each month to do summary meeting for the previous months's information with the consulting Pharmacist (according to his schedule). She indicated she may have more information from the physician and Behavior committee in her computer, and would review that.</p> <p>In an interview on 5/10/13 at 10:48 A.M., the Social Service Director indicated the Nurse Practitioner did not consider GDR from Pharmacy recommendation in August, 2012 because Pharmacist did not suggest a decrease in any medication except the Lorazepam. She indicated she had reviewed current PHQ-9 scores and they were still showing mild depression. She did not know why the resident was on 2 anti-depressant, but it was not uncommon to have one augment another.</p>			

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	<p>In an interview on 5/14/13 at 9:20 A.M., the ADON (Assistant Director of Nursing) indicated the Social Service Director was the "expert" on behavior monitoring and the GDR process. She indicated she (the ADON) was at the meeting in April when a GDR was discussed for this resident. The ADON indicated the Social Service Director recorded the information discussed in the meetings.</p> <p>In an interview on 5/14/13 at 9:52 A.M., the ADON indicated she, the DON, the Social Service Director, and the Pharmacist talked about the resident in the behavior/psychotropic medication meeting. They used the MDS Section D (Mood) and PHQ-9 score to determine her level of depression. She indicated this resident's December and March scores were unchanged. She did not recall extent of resident's illness (pneumonia) in March, and did not consider that the resident's illness might have impacted the score at that time. The ADON indicated she did not believe there was any other documentation recorded related to the discussion.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>						

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F000431 SS=D	<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>Based on record review, observation, and interview, the facility failed to ensure all insulin's had the open date on them, and over the counter</p>	F000431	F 431  #1 No residents were listed as being affected by the deficient practice.	06/07/2013			

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NAME OF PROVIDER OR SUPPLIER  MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medications had the physician name on the bottle for 2 of 6 medication carts observed during medication storage review.</p> <p>Findings include:</p> <p>During the medication storage review on 5/14/13 at 12:40 p.m., with LPN #2, the Hallway 3 medication cart had one open bottle of Novolog insulin with no open date on it. The Hallway 1 medication cart had 2 bottles of Humalog insulin with no open dates. The Hallway 3 medication cart was observed to have 2 bottles of supplements and 1 bottle of Tylenol OTC (over the counter) medications with resident name on them, but no physician name.</p> <p>In an interview with LPN #2 on 5/14/13 at 12:43 p.m., she indicated she was unsure of the policy regarding over the counter medications and what was to be written on the bottle. She indicated the bottles of insulin should have an open date written on them when opened.</p> <p>A request for the policy regarding over the counter drug labeling and dating of insulin's was requested on 5/16/13 at 8:30 a.m.</p>		<p>The 2 bottles of supplements and 1 bottle of Tylenol located in the hallway 3 medication cart had the physician name placed on them. The Novolog located in the hallway 3 medication cart that was not dated was discarded, replaced, and dated after opened. The 2 bottles of Humalog insulin on the hallway 1 medication cart that were not dated were discarded, replaced, and dated after opened.</p> <p>#2 Residents who utilize "over the counter" medications and medications that require an "opened on" date have the potential to be affected by this deficient practice. A facility audit was performed by the DNS/designee on 5.16.13 to ensure that all "over the counter medications" were labeled with the resident name and physician name. A facility audit was performed on 5.16.13 by the DNS/designee to ensure that all medications that required an "opened on" date had a date placed once opened.</p> <p>#3 An in-service will be provided to all licensed nursing staff by the DNS/designee by 6.07.13 regarding the labeling and dating of medications. All "over the counter" medications will be labeled with the resident name and physician. All medications that require an "opened on" date will have a date placed upon opening. DNS/designee</p>		

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	<p>A policy provided by the ADON (Assistant Director of Nursing) on 5/16/13 at 10 a.m., from the facility pharmacy titled "Labeling of Medication" indicated, "...Labeling for all medications must be: ...Typed or printed and clearly indicate... Prescriber's name...." No documentation regarding dating of insulin's was provided.</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l)</p>		<p>will make daily rounds to ensure compliance.</p> <p>#4 To ensure compliance, the DNS/Designee is responsible for the completion of the medication labeling and dating CQI audit tool bi-weekly x 4 weeks, weekly x 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>#5 Date of Compliance: 06/07/2013</p>		

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F000441 SS=D	<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. <b>Based on record review, observation and interview, the facility failed to</b></p>	F000441		06/07/2013	

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	<p>ensure proper procedure of sanitization of a glucometer for 1 of 2 observations of sanitizing glucometers during the medication pass.</p> <p>Findings include:</p> <p>During the medication pass, LPN #1 was observed passing medications at 4:15 p.m., on 5/9/13. LPN # 1 wiped the surface of the glucometer off for 20 seconds, then placed it into the plastic bag it had been stored in and put it back into the medication cart.</p> <p>In an interview with LPN #6 on 5/9/13 at 11:30 a.m., she indicated they are supposed to keep the glucometer wet for 2 minutes and dry for 30 seconds.</p> <p>A document titled "Glucose Meter Cleaning &amp; Testing", dated 9/7/11 with review dates of 9/2011, 9/23/2011, 9/2012, 3/2013, indicated, "...wipe entire external surface of the blood glucose meter with wipe for 2 minutes...Allow meter to completely dry...."</p> <p>3.1-18(j)</p>		<p>F 441</p> <p>#1 No residents were listed as being affected by the deficient practice. The glucometer referenced as being cleaned for 30 seconds by LPN #1 was removed from the bag, wiped for 2 minutes and allowed to completely dry prior to being placed into a new bag.</p> <p>#2 Other residents that reside on this hall and who require the use of a glucometer had the potential to be affected be the deficient practice. The glucometer was removed from the bag, wiped for 2 minutes and allowed to completely dry prior to being placed into a new bag. A skills validation was performed by the DNS/designee with LPN #1 regarding the cleaning and storage of glucometers.</p> <p>#3 All licensed staff will perform skills validations with the DNS/designee regarding the cleaning and storage of glucometers by 6.07.2013. All glucometers will be wiped for 2 minute allowed to completely dry and placed into a bag. An inservice will be provided to licensed staff by 6.07.13 by the DNS/designee regarding the cleaning and storage of glucometers. The DNS/designee will conduct daily rounds to ensure compliance.</p> <p>#4 To ensure compliance, the</p>		

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			<p>DNS/Designee is responsible for the completion of the glucometer cleaning and storage CQI audit tool bi-weekly x 4 weeks, weekly x 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>#5 Date of Compliance: 06/07/2013</p>	