

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/09/2013
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NAME OF PROVIDER OR SUPPLIER  PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: August 5, 6, 7, 8, 9, 2013</p> <p>Facility number: 000254 Provider number: 155363 AIM number: 100266270</p> <p>Survey team: Dorothy Watts, RN TC Martha Saull, RN Terri Walters, RN Sylvia Martin, RN</p> <p>Census bed type: SNF: 2 SNF/NF: 40 Total: 42</p> <p>Census Payor source: Medicare: 1 Medicaid: 37 Other: 4 Total: 42</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 14, 2013, by Jodi Meyer, RN</p>	F000000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a resident with a walking boot, who developed unstageable pressure areas beneath the boot, had a care plan to address the management and care of the boot and/or skin beneath for 1 of 1 resident's reviewed with a walking boot. Resident #33</p> <p>Findings include:  On 8/7/13 at 2 P.M., the clinical record of Resident #33 was reviewed.</p>	F000279	<p>Resident #33 cited in the deficiency no longer resides at the center.</p> <p>The other residents with orthopedic support devices plans of care have been assessed by Interdisciplinary team and updated to accurately reflect the resident's needs.</p> <p>The center's licensed nursing staff has been retrained on proper skin care and treatment for residents with orthopedic support devices and proper care planning for residents with orthopedic support devices.</p> <p>The Director of Nursing or assistant director of nursing will</p>	09/08/2013	

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	<p>Diagnoses included, but were not limited to, the following: Right foot and toe fracture, traumatic fracture of right toe and history of peripheral edema. The MDS (Minimum Data Set Assessment) dated 5/20/13 indicated the following for the resident: moderately impaired cognition; "yes" for pressure ulcer risk; currently had no pressure ulcers.</p> <p>Nurses notes dated 5/13/13 at 7 P.M. indicated the following for the resident: "...new admit...from (name of hospital)...non wt (weight) bearing of rt (right) foot d/t (due to) fx (fracture) of foot and toe. Boot cast applied..."</p> <p>A "Skin Integrity Assessment: Prevention and treatment Plan of Care" was dated 5/14/13 and included, but was not limited to, the following: "Braden Risk Assessment Score: 18. At risk 15 - 18...Very high risk (score of 9 or below)...Frequent turning...protect heels, manage...friction and shear...pressure reduction support surfaces..."</p> <p>Interventions included, but were not limited to, the following: "...protect elbows and heels if being exposed to friction and shear...inspect the skin for s/s (signs and symptoms) of breakdown...provide padding for</p>		<p>audit care plans of all new admissions to ensure all orthopedic devices are addressed in the plan of care weekly times 4 weeks and monthly thereafter. The results of these audits will be reported to the Quality Assurance team monthly for review and recommendations.</p>		

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	<p>casts, braces, splints..."</p> <p>A Physician Progress note, dated 6/12/13, from (name of Foot and Ankle Physician) indicated the following: "Patient injured right foot approximately 1 month ago. At that time went to (name of hospital emergency room)...Placed in walking boot...placed in nursing home...patient still in walking boot...there are, however, numerous dark red pressure sores due to cast being too tight. None have ulcerated as of yet..."</p> <p>On 8/8/13 at 8:50 A.M. the DON was interviewed. The DON indicated there was no order to take the boot off or to leave it on, no order directing staff what to do with the boot. The DON indicated since there was no physician order for the boot, they did not have a care plan to address the care and maintenance of the boot and/or skin beneath. The DON indicated at the time, nursing staff should have documented the presence of the walking boot, and notified the physician for clarification on the care and/or removal of the boot and skin care parameters.</p> <p>3.1-35(b)(1)</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure the care plan was followed in regard to a daily assessment of a renal dialysis fistula site for 1 of 1 dialysis resident reviewed.</p> <p>Resident #25</p> <p>Findings include:</p> <p>On 8/9/13 at 8:21 A.M., Resident #25's clinical record was reviewed. His diagnoses included but were not limited to: End Stage Renal Disease/Dialysis and Diabetes Mellitus. His August 2013 physician's orders included but were not limited to: Dialysis on Mondays, Wednesdays, and Fridays.</p> <p>His current care plan dated 5/27/13, addressed nursing care in regard to renal hemodialysis. One of the interventions addressed the monitoring of the functional fistula access site. Instructions indicated, "Check A/V (Arterial/Vascular) fistula/graft function by palpating thrill and listening for bruit (buzz) daily and</p>	F000282	<p>Resident #25's dialysis fistula is being monitored daily per physician's orders beginning 8/9/13 and recorded on the TAR. Other dialysis resident care plans have been reviewed to ensure that the plan of care instructions are being followed.</p> <p>The center's licensed nurses have been retrained on the center policy and procedure for following resident plans of care. The Director of Nursing or assistant director of nursing will audit the TAR daily 5 times per week times four weeks and then weekly thereafter to ensure the dialysis patient's care plans are being followed and results documented on the TAR as required. The Director of Nursing will report findings to the center Quality Assurance Team monthly for review and recommendations.</p>	09/08/2013

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	<p>record on the TAR (Treatment Administration Record)."</p> <p>On 8/9/13 at 9:12 A.M., Resident #25's nurse LPN #14 was interviewed regarding Resident # 25's dialysis care. She indicated the monitoring of the resident's dialysis fistula site was documented on the Dialysis Center Communication Record on each dialysis day. She indicated the record was sent to dialysis with the resident and returned back to the facility when the resident returned from dialysis. She indicated the assessment of the bruit and thrill of the fistula site was documented on the Dialysis Center Communication Record three times a week when the resident returned from dialysis. A daily documentation was lacking of the assessment of the bruit or thrill of the fistula site except three times weekly when the resident returned from dialysis.</p> <p>On 8/9/13 at 10:15 A.M., the Assistant Director of Nursing (ADON) was observed writing a physician's telephone order for Resident #25. The order indicated, "Check AV fistula/graft functions by palpating thrill et listening for bruit (buzz) daily." The ADON indicated the fistula dialysis site needed to be assessed daily.</p>			

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	<p>On 8/9/13 at 10:24 A.M., the Director of Nursing (DON) on interview indicated an intervention to assess the fistula site daily was on Resident #25's care plan and had been missed.</p> <p>On 8/9/13 at 10:30 A.M., the facility policy entitled, " Dialysis Management (Hemodialysis)" (Revised April 2012) was received and reviewed. The policy included but was not limited to: "...17. Check AV fistula/graft site function by palpating the thrill and listening for bruit daily and upon return post-dialysis and document on the TAR (Treatment Administration Record)..."</p> <p>3.1-35(g)(2)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure a resident was offered opportunity to shower and/or bathe for 1 of 2 reviewed for activities of daily living and cleanliness. Resident #16</p> <p>Findings include:</p> <p>On 8/5/13 at 2 P.M. Resident #16 was observed in his room. A pervasive body odor was noted throughout the room.</p> <p>On 8/5/13 at 3 P.M., the clinical record of Resident #16 was reviewed. Diagnoses included, but were not limited to, the following: Bipolar, depression, diabetes mellitus and dementia. The most recent MDS (minimum data set assessment) dated 7/9/13 indicated the following for the resident: independent cognition; extensive assistance required for personal hygiene and 1 person physical assist required for bathing activities.</p>	F000312	<p>Resident #16 is being offered a shower three times a week with re-attempts if he refuses. Refusals are being documented in the resident bathing record. All other residents bathing records have been reviewed and showers or baths have been given per resident request and center policy. Resident refusals have been documented on the resident bathing record. The center's nursing staff has been retrained on the center policy and procedure offering showers and baths to residents and documentation of resident refusals as well as alternate strategies for encouraging resident bathing. The Director of Nursing or the Assistant Director of Nursing will review resident bathing records five days per week times two weeks then weekly thereafter to ensure continued compliance. Findings will be reported to the center Quality Assurance committee monthly for review and recommendations.</p>	09/08/2013	

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	<p>Progress notes, dated 7/6/13 indicated the resident "...does own personal care/hygiene per self once supplies are given to him. Receives showers twice a week with supervision for safety..."</p> <p>A progress note dated 7/8/13 indicated the following: "Discussed with resident personal hygiene emphasizing the health issues related to failure to bathe. Resident expressed understanding. States will try to be better about bathing."</p> <p>A Progress note dated 7/9/13 indicated "...resident stays in room most of day...needs much encouragement to shower..."</p> <p>A plan of care, dated 7/11/13, indicated the following problem: "Potential or actual ADL (activities of daily living) deficit r/t (related to) dementia as evidenced by resistant to therapy/ADL's." Interventions included, but were not limited to, the following: assist/encourage/provide per resident preference shower provide 1 assist; Explain reasons for need of shower reapproach/ask him to schedule his shower (when he would like to have it) 8/6/13.</p>						

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	<p>Social Service noted dated 8/6/13 indicated the following: "Double checked w/nurse (with nurse) related to res (resident) shower habits. He likes to wash self in "sinkbath." He usually doesn't get in shower. He has several toiletries, deodorant, cologne, etc. to use. Res has history of poor hygiene..." The entry was signed by the DON (Director of Nursing). Then the next day, a progress note was dated 8/7/13 and included, but was not limited to, the following:</p> <p>"...discuss with resident the impact of not bathing routinely. Reviewed diabetes risks for skin issues. Followed up on discussion on hygiene..."</p> <p>On 8/7/13 at 10 A.M., the Resident was observed in his room. The pervasive body odor continued to be noted throughout the room.</p> <p>On 8/7/13 at 10 A.M., the DON provided a copy of the "Bath Detail Report" for the time frame 6/8/13 - 8/3/13, 8 weeks and/or 16 opportunities for shower/bath. During the period, it was documented the resident had two refusals; 1 bath and 7 showers. All remaining opportunities were documented on the report as "not scheduled."</p>			

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	<p>On 8/9/13 at 7:45 A.M., a current copy of the CNA (certified nursing assistant) assignment sheet was reviewed. The form indicated the resident received showers.</p> <p>On 8/9/13 at 7:58 A.M., CNA #1 was interviewed. She indicated if a resident refuse to shower, she tells the nurse and then offers the resident to shower again for a total of 3 - 4 times. CNA #1 indicated showers are documented in the KIOSK (facility computer system). She indicated when a resident refuses a shower, it is documented in the KIOSK "refused." She indicated CNAs document in the KIOSK "not scheduled" for example, on day shift and the resident was scheduled to get showers until the eveing shift."</p> <p>On 8/9/13 at 9:19 A.M., the DON was interviewed. She indicated the resident was scheduled for showers three times a week because he refuses. The DON indicated this gives staff more oppourtunities to have the conversation with the resident about him really needing showers. She indicated if a resident refused a shower, it was documented in the KIOSK as "refused or resist care." The DON indicated they want the resident to have at least two a week,</p>			

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview and record review, the facility failed to ensure a resident with a walking boot did not develop 6 pressure sores, of which 3 were unstageable, beneath the walking boot for 1 of 1 residents reviewed for pressure sores with boot type devices. Resident # 33</p> <p>Findings include:</p> <p>On 8/7/13 at 2 P.M., the clinical record of Resident #33 was reviewed. Diagnoses included, but were not limited to, the following: Right foot and toe fracture, traumatic fracture of right toe and history of peripheral edema. The MDS (Minimum Data Set Assessment) dated 5/20/13 indicated the following for the resident: moderately impaired cognition; extensive assistance for bed mobility,</p>	F000314	<p>Resident # 33 no longer resides in the center.</p> <p>All residents have had skin reviewed to ensure no other unidentified skin areas are present. No other residents were found to be impacted.</p> <p>All nursing staff has been retrained on the center policy for skin care and pressure ulcer prevention, to include care of residents with orthotic devices. The Director of Nursing or the assistant director of nursing will review all residents with orthotic devices on admission and weekly thereafter to ensure proper monitoring for skin issues is in place per policy including but not limited to obtaining physician orders for skin checks under removable devices and documentation of skin assessment. Any identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per center</p>	09/08/2013			

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	<p>transfers and personal hygiene; "yes" for pressure ulcer risk; currently had no pressure ulcers.</p> <p>Nurses notes dated 5/13/13 at 7 P.M. indicated the following for the resident: "...new admit...from (name of hospital)...non wt (weight) bearing of rt (right) foot d/t (due to) fx (fracture) of foot and toe. Boot cast applied...no edema to BLE (bilateral lower extremities) noted. Toes of rt foot warm with &lt; 3 sec (second) cap (capillary) refill..."</p> <p>A "Skin Integrity Assessment: Prevention and treatment Plan of Care" was dated 5/14/13 and included, but was not limited to, the following: "Braden Risk Assessment Score: 18. At risk 15 - 18...Very high risk (score of 9 or below)...Frequent turning...protect heels, manage...friction and shear...pressure reduction support surfaces..."</p> <p>Interventions included, but were not limited to, the following: "...protect elbows and heels if being exposed to friction and shear...inspect the skin for s/s (signs and symptoms) of breakdown...provide padding for casts, braces, splints..."</p> <p>Nurses notes dated 6/12/13 at 1 P.M., indicated the resident "LOA (leave of</p>		<p>policy.</p> <p>The Findings will be reported by the Director of Nursing to the center Quality Assurance Committee monthly for review and recommendation.</p>				

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	<p>absence) to appt (appointment) at (name of Foot and Ankle Physician)."</p> <p>Nurses notes were reviewed from 5/13/13 to 6/12/13 and documentation was lacking of the circulatory status being checked twice a day to the right foot on all days, with the exception of 5/27/13.</p> <p>A Physician Progress note, dated 6/12/13, from (name of Foot and Ankle Physician) indicated the following: "Patient injured right foot approximately 1 month ago. At time went to (name of hospital emergency room)...Placed in walking boot...placed in nursing home...patient still in walking boot...there are, however, numerous dark red pressure sores due to cast being too tight. None have ulcerated as of yet..."</p> <p>A facility nursing progress note dated 6/12/13 at 2:30 P.M., indicated the following: "...noted several pressure areas to right foot: 1. Right side mid foot unstageable (full thickness tissue loss in which the base of the ulcer is covered by...eschar (tan, brown or black) in the wound bed...measuring 1.3 cm (centimeters) x 2.2 cm with eschar. 2. Right side of foot near pinkie toe</p>			

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	<p>measuring 2.1 cm x 1.7 cm, unstageable with eschar;</p> <p>3. Bottom of great toe stage 1 (intact skin with non-blanchable redness of a localized area usually over a bony prominence) measuring 0.3 cm x 0.2 cm;</p> <p>4. Top of right foot near bunion stage 1, measuring 0.2 cm x 0.4 cm;</p> <p>5. Left top of right foot stage 1 measuring 0.3 cm x 0.4 cm;</p> <p>6. Left side of right foot bunion unstageable measuring 1.8 cm x 1.7 cm."</p> <p>On 8/8/13 at 8:07 A.M., the Physical Therapy (PT) Director was interviewed. She indicated the resident was admitted on 5/13/13, with a boot type device on her right foot. The PT Director indicated the resident was NWB (non weight bearing) to her right foot initially and required total assistance for transfers on admission. The PT Director indicated the resident began Physical Therapy on 5/14/13. She indicated upon admission, the resident had a walking type boot on her right foot that was capable of being removed, although there was no order to do so. The PT Director indicated Physical Therapy did "nothing with the boot." She indicated the resident was seen at the foot and ankle specialist on</p>			

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	<p>6/12/13 and the resident was discharged home on 7/2/13.</p> <p>On 8/8/13 at 8:50 A.M. the DON was interviewed. She indicated the boot to the right leg, covered the leg from just below the knee to the foot, with the area from the base of the toes to the tips of the toes being exposed. She indicated there were velcro straps on the boot so the boot could have been removed. The DON indicated there was no order to take the boot off or to leave it on, no order directing staff what to do with the boot. The DON indicated staff should have checked the toes for warmth and blanching and should be done at least twice a day. The DON indicated this should be documented in nurses notes and /or the treatment administration record (TAR). The DON indicated when the resident returned on 6/12/1, she had an order to wear street shoes and leave the boot off. The resident was discharged home on 7/2/13.</p> <p>On 8/9/13 at 9:40 A.M., the DON (Director of Nursing) was interviewed. She indicated when the resident returned to the foot and ankle specialist on 6/12/13 and had the walking boot initially removed, the facility was made aware of the</p>						

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	<p>pressure sores to the resident's right ankle. The DON indicated at the time, they saw they had an opportunity for improvement. She indicated they did a detailed analysis of the resident and/or her stay at the facility from admission to 6/12/13. The DON indicated the analysis revealed the facility did not have a copy of discharge instructions from the emergency room and/or did not have a physician order for the boot on the facility admission orders. The DON indicated the boot was not identified on the facility admission skin assessment. The DON indicated when a new resident is admitted to the facility, team members are to go to the resident's room and introduce themselves. She indicated when team members went to the resident's room, they didn't see the boot as it was covered by a sheet.</p> <p>The DON indicated on admission, the resident's Braden Skin Risk assessment indicated she was a low risk to develop pressure sores. The DON indicated the nurses did not remove the resident's walking boot as there was no order to remove the boot. She indicated at the time, the facility should have had orders to address care and monitoring of the boot and right extremity. She indicated the nurse performing the</p>				

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	<p>weekly skin assessments did not remove the boot because there was no order to do so. The DON indicated at the time, nursing staff should have documented the presence of the walking boot, and notified the physician for clarification on the care and/or removal of the boot, skin care parameters</p> <p>On 8/9/13 at 10 A.M., the DON was interviewed. She indicated the facility should have monitored the circulatory status of the resident's right foot, while the boot was in place. She indicated this would include, but was not limited to, the warmth of the toes, capillary refill (applying pressure to the nail beds to assess circulation of the extremity) of the toe nail beds and edema. The DON indicated the circulatory status of the foot should have been monitored on the day and evening shift. She indicated this would be documented in the nurse ' s notes. The DON indicated when the resident saw the foot and ankle specialist on 6/12/13, it was noted the resident had edema. She indicated the resident had traveled to the physician's office so had her leg down, thus contributing to the edema noted by the specialists.</p> <p>3.1-40(a)(1)</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 observation, interview and record review the facility failed to ensure that medications with expiration dates had the opened</p>	F000431	The improperly dated and expired medications were removed from the cart on 8/8/13. Current medications have been reviewed and no other expired or	09/08/2013			

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	<p>dates documented and/or disposed of expired medication for 2 of 2 medication rooms/carts.</p> <p>Findings include:</p> <p>1. During the review of East Unit's medication storage room on 8/8/13 at 2:35 P.M., one opened multidose vial (10 doses per vial) of Aplisol (medication used to administer tuberculosis skin test) was located in the refrigerator. The bottle's opening date (handwritten on the vial) was documented as 6/27/13.</p> <p>The facility's policy and procedure for proper drug disposal (Section 4 of Policy 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles) was reviewed on 8/9/13 at 2:00 P.M. The manufacturer's recommendation for the disposal of Aplisol (obtained from www.jhppharma.com) was 30 days after initial opening.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 8/9/13 at 2:40 P.M., the ADON indicated that the facility's policy was to date Aplisol when it was initially opened and then discard the medication 30 days after the recorded opening date.</p>		<p>undated open medications were found.</p> <p>The center's licensed nurses have been retrained on the facility policy for dating and storage of medications.</p> <p>The Director of Nursing or assistant director of nursing will review medications weekly times four weeks and monthly thereafter to ensure all medications are dated appropriately and replaced when expired or per manufacturer guidelines. The director of nursing will report findings monthly to the center Quality Assurance team for review and recommendation.</p>				

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	<p>2. During a review of West Unit's medication cart on 8/8/13 at 2:55 P.M., the initial opening date of one 2.5 mg bottle of Travantan 0.004% eye drops belonging to Resident #8 was undocumented. Travantan's manufacturer's recommendation was as follows: "...do not use more than 30 days after opening." The manufacturer's recommendation was found at the manufacturer's website <a href="http://www.home.intekom.com/pharm/alcon/Travatan.html">www.home.intekom.com/pharm/alcon/Travatan.html</a>.</p> <p>The opening date of one opened, partially used bottle of Fluticasone 50 Mcg belonging to Resident #18 was undocumented.</p> <p>3. During an interview with LPN #14 on 8/8/13 at 3:05 P.M., LPN #14 indicated that, in compliance with the facility's policy and procedure, all liquid medications should be dated when initially opened.</p> <p>The facility ' s policy and procedure titled, " 5.3 Storage and Expiration of Medication, Biological, Syringes and Needles", was provided by the Director of Nursing on 8/9/13 at 2:00 P.M. The policy and procedure 5 stated: "Once any medication or biological package has been opened, Facility should follow</p>			

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	<p>manufacturers/supplier guidelines with respect to expiration dates for opened medication." Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."</p> <p>3.1-25(o)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to ensure housekeeping and maintenance services were provided to maintain the facility in a safe and/or sanitary condition in regards to a unsecured TV; stained and water damaged walls for 7 residents rooms out of 24 rooms reviewed. Rooms 13, 14, 16, 17, 24, 29, 34</p> <p>Findings include:</p> <p>1. During the initial tour of the facility on 8/5/13 at 1:00 P.M., an unsecured flat screen TV was observed in Room 34 to be elevated 6 ft high on a wooden shelf. The TV power cord was hanging down behind the TV and running along the wall unsecured to the wall at 23 inches above the floor. The TV power cord was plugged into a power strip that was hanging unsecured to the wall at 23 inches above the floor. The power strip was plugged into an outlet that was located 36 inches above the floor. Located in the window of the room was an air conditioner unit beneath which a 5 inch by 8 inch area of</p>	F000465	<p>The resident rooms # 13, 14, 16, 17, 24, 29, 34 have had plaster repaired on walls and near windowsills by a licensed contractor. The gaps in window air conditioners have been sealed. The electrical cords in room 34 have been secured and the television has been secured. The identified resident areas have been reviewed and a contractor was retained to repair peeling plaster, remove any black substances and repair windowsills. The identified electrical cords have been secured. Facility maintenance staff has been retrained on the facility policy for maintaining plaster walls and securing electrical cords. The Nursing Home Administrator and the maintenance director will perform rounds weekly times 4 weeks and monthly thereafter to ensure continued compliance. The maintenance director will report to the center Quality Assurance committee monthly for review and recommendations.</p>	09/08/2013			

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	<p>plaster was cracked and peeling away from the wall. Wedged between the air conditioner unit and the window sill was a white washcloth.</p> <p>During an interview with the Health Care Administrator (HCA) and Maintenance Supervisor (MS) on 8/9/13 at 1:08 P.M., the HCA indicated the facility would remove the cords and secure the TV to the shelf immediately.</p> <p>2. On 8/6/13 at 9:15 A.M., a window in Room 14 had a 4 inch window sill that extended out from the window, framing all four sides of the window. Located inside of the 4 inch window sill was a 4 inch by 5 inch rough, unfinished, spackled area. There was a brown, unidentifiable substance which covered 75 percent of the roughly spackled area. The brown, unidentifiable substance was also observed running down the wall from the window sill to 6 inches above the floor. The Formica (counter top material) that covered the bottom ledge of the window sill was bowing out, leaving gaping areas along the sill. In the corner of the room between the closet door and the room's exterior wall, a plaster area which was 8 inches in width extended from the ceiling to the floor. The</p>			

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	<p>plaster of this 8 inch area was bulging and popping off the wall, leaving a black, unidentifiable substance exposed. The plaster near the ceiling and near the closet door inside the resident's closet on the exterior wall was popping off and missing.</p> <p>3. On 8/6/13 at 10:30 A.M., an air conditioner unit was located in the window of Room #13. The caulking that was sealing the Formica window sill in which the air conditioning unit was located had a black mold like substance extending from beneath the caulking onto the Formica. The corner at the right side of the window where the Formica and the window sill meet had a black mold like substance extending on to the Formica.</p> <p>The plaster between the closet door and the exterior wall which was 5 feet in height by 6 inches in width had plaster that was popping away and missing.</p> <p>4. On 8/8/13, rooms 16, 17, 24, 29 were observed to have air conditioner units located in the windows of the residents rooms. The plaster beneath the windows was cracking, bulging and popping away from the wall.</p> <p>5. During an interview with the</p>						

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	<p>Healthcare Administrator (HCA) and the Maintenance Supervisor (MS) on 8/9/13 at 1:10 P.M., the HCA and the MS indicated the previous roof had leaked and that a new roof had been installed sometime during this past year. After having been informed of the appearance of a black, unidentifiable mold like substance behind the plaster in the corner of Room # 34, the HCA and the MS indicated that they would investigate to determine what the substance was and complete the necessary repairs.</p> <p>During an in interview with the Maintenance Supervisor on 8/9/13 at 2:34 P.M., he indicated the water damage caused by the roof leaking was bad in some of the rooms. The MS indicated the facility will need to get a crew in the building to work on the walls. He indicated everything needs to come out of water damaged rooms.</p> <p>3.1-19(f)</p>			