STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155519	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTLECARE OF VINCENNES	1202 S 16TH ST VINCENNES, IN 47591

(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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00138622. Complaint number #IN00138622 - Unsubstantiated-due to lack of evidence. Survey dates: December 2, 3, 4, 5, 9, 2013 Facility number: 000357 Provider number: 155519 AIM number: 100291370 Survey team: Terri Walters RN TC Dorothy Watts RN 12/2, 12/3, 12/4, &12/5/13 Sylvia Martin RN 12/2, 12/3, 12/4, & 12/5/13 Diana Perry RN 12/2, 12/3, 12/4, & 12/5/13 Anna Villain RN 12/2, 12/3, 12/4, & 12/5/13 Census bed type: SNF/NF: 46 Total: 46	F000000	This plan of correction is submitted to serve as an allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the allegations or conclusions set forth in the statement of deficiencies. We are in compliance as of 01/08/2014 and respectfully request paper compliance review for the recertification and state licensure survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency 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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	Census payor type: Medicare: 8 Medicaid: 30 Other: 8 Total: 46 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on December 13, 2103, by Jodi Meyer, RN			

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F000281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.			
	Based on observation, interview, and record review, the facility failed to ensure an transdermal drug patch was rotated from site to site when administered to prevent the same site administration for a 14 day administration period for 1 of 1 resident who had been administered a transdermal patch during a medication pass. Resident # 25 Findings include: On 12/5/13 at 11:39 A.M., Resident #25 was observed sitting in her wheelchair in her room during a medication pass. At that time, RN #5 removed the Exelon transdermal patch dated 12/4(2013) from the resident's left anterior upper chest. She then applied a new transdermal Exelon patch dated 12/5 (2013) to Resident #25's left upper back. On 12/5/13 at 12:21 P.M., Resident #25's December 2013 Medication Administration Record (MAR) was reviewed with RN #5. The MAR	F000281	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED: The Director of Nursing assessed Resident #25 and determined there were no adverse effects from the facility's rotation of the Exelon trans dermal patch. IDENTIFICATION OF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: The Director of Nursing identified residents with physician orders for the Exelon trans dermal patch as having the potential to be affected. The Director of Nursing in-serviced all nurses (12/12/13) on manufacturers recommendations (Exhibit 1) regarding use of the Exelon trans dermal patch. MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCES: The Director of Nursing and Assistant Director of Nursing developed a tracking device (Exhibit 2) allowing for proper placement of the Exelon patch according to the manufacturers recommendations. All nurses were in-serviced 12/12 /13 on the use of the tracking device (Exhibit 2). The tracking device was fully implemented by nursing on 12/15/2013. CORRECTIVE	01/08/2014

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	included but was not limited to: "...EXELON 4.6 MG (milligrams)/24 HR (hour) PATCH. APPLY 1 PATCH DAILY..." Documentation included a blank box entitled "11 AM" for the nurses ' initials (for nurse who administered the patch) and a blank box entitled "SITE" for initials (initials of area the patch had been applied). Documentation of the site for 12/1/13 was RF (right front), 12/2/13 was LF (left front) 12/3/13 was RF (right front), 12/4/13 was LF (left front) and 12/5/13 was LB (left back). During interview with RN # 5 at that time she indicated the nurses document the site used for the patch placement on the MAR. She also indicated the nurses by reviewing the MAR daily ensure the patch placement was not applied to the same site for 2 days consecutively (when old patch removed and new patch applied). Resident #25's clinical record was reviewed on 12/5/13 at 11:55 A.M. Her current diagnoses included but were not limited to: dementia, cardiovascular disease, and Parkinson's disease. Resident #25's current December 2013 physician orders included but were not limited to: "... EXELON 4.6 MG/24 HR PATCH. APPLY 1		ACTION MONITORED: The Consultant Pharmacist will review the tracking devices monthly to ensure proper placement of the Exelon trans dermal patch. Results of these reviews will be reported monthly to the Director of Nursing and to the facility Continuous Quality Improvement Committee (CQI). The Role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. IDR request due to the fact the Surveyor is requiring a detailed tracking device that the Manufacturer of the Exelon Patch doers not provide to either the Pharmacy or the Facility. The tracking device offered by the Exelon Manufacturer is not provided in the products packaging. The Exelon Manufacturer offers a tracking	

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	PATCH DAILY..." The facility's drug handbook entitled, "Nursing 2014 DRUG HANDBOOK" page 1226 indicated: Exelon patch transdermal: "... Change the site daily, and don't use the same site within 14 days..." On 12/5/13 at 2:09 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed in regard to Exelon patch administration for Resident #25. They were made aware documentation was lacking in Resident #25's MAR to ensure site placement had not been repeated within 14 days. The DON and ADON indicated at that time current facility documentation didn't ensure that patch placement had not been repeated in 14 days. 3.1-35(g)(1)		device on their web site. However, their tracking device is not detailed enough to meet Surveyor standards noted in F281. The facility was held to a higher standard than the Manufacturer of the Exelon Patch in the need to create a detailed tracking device and should not be cited for the Manufacturer's failure to provide a tracking device that meets their own recommendations.(ADDENDUM: The Consultant Pharmacist and Director of Nursing will monitor on an on-going basis).	

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F000312 SS=D	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 that each resident received the care and services needed for 2 of 2 residents who were unable to carry out ADLs , which required extensive or partial assistance with personal hygiene. Resident #10, Resident #15 Findings include: 1. On 12/4/13 at 2:32 P.M. Resident #10's care was observed. At that time ,CNA # 2 was interviewed, she indicated the resident had been incontinent of urine. CNA #4 and CNA #2 were observed to prepare to provide personal care to the resident. CNA# 2 was observed to wash the resident's buttocks first. Then with the same soap, washcloth, and water the resident 's peri-area was cleansed. She was observed to wash in a circular motion from one side, under vulva, and around to the other side. She rinsed the peri-area one time	F000312	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED: The Director of Nursing assessed resident #10 and #15 anddetermined there were no adverse affects from the perineal care provided by CNA#2, CNA #3 and CNA# 4. IDENTIFICATION OF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: The Director of Nursing identified residents requiring extensive orpartial assistance with perineal care as having the potential to beeffected. The In-Service Coordinator in-serviced CNA#2, CNA#3 and CNA#4 (12/5/13) on the facility" Perineal Care Policy" (Exhibit3). MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCES: The In-Service Coordinator will in-service all CNA'son the facility "Perineal Care Policy" (Exhibit 3) (12/12/13). The In-Service Coordinator will test (by means of written exam) all CNA's onthe facility "Perineal Care Policy" (1/8/14). This testing will bedone monthly and will require all CNA's to exhibit proficiency in theaforementioned policy. Failure	01/08/2014

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	with the same circular motion and rubbed, not patted, the area dry. As CNA #2 completed care she was observed to pour the basin of water down the sink. On 12/4/2013 at 3:30 P.M., the policy for Peri-Care was requested from RN #10. Resident #10's, clinical record was reviewed on 12/5/2013 at 9:00 A.M. The resident's diagnoses included, but was not limited to dementia and depression. A 10/15/2013 quarterly MDS (Minimum Data Set) indicated Resident #10 required extensive assistance (two person) for toileting and personal hygiene, was frequently incontinent of urine (more than 7 episodes) and frequently incontinent of bowel (more than 2 episodes). On 12/5/2013 at 4:00 P.M., RN #11 indicated no procedure was found related to peri-care. On 12/9/2013 at 3:50 P.M., the facility perineal care policy titled Perineal Care (revised 2010) was received and reviewed. The policy included but was not limited to: "...PROCEDURE: wipe from front to back and from center of		to successfully pass this exam after threeattempts will result in the suspension of the CNA until a successful exam isachieved. Newly hired CNA's will be tested during orientation. TheIn-Service Coordinator will skill- test all CNA's on the facility"Perineal Care Policy" no later than 1/8/2014. The In-Service Coordinator will skill- testall CNA"S bi-annually thereafter and newly hired CNA"s duringorientation. Failure to successfullypass this skill test after three attempts will result in the suspension of theCNA until a successful skill test is achieved. CORRECTIVE ACTION MONITORED:The Director of Nursing will review results of CNA testing regardingfacility "Perineal Care Policy" monthly. The results will bereported to the facility Continuous Quality Improvement Committee (CQI). Therole of the CQI Committee (per facility Policy and Procedure) is to establish andconduct an extensive and objective program of assessment, reporting andmonitoring in order to assure provision of optimal services in regard toresident care satisfaction and quality of life. The committee isresponsible for identifying and monitoring areas that require prevention andcorrective actions. The committee also assists in thedevelopment and initiation of plans of correction related to	

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	peri area outward to thighs. Change washcloths as necessary. FEMALES: a) Separate labia. Wash urethral area first b) Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs, Use different parts of washcloth for each stroke. " 2. Resident #15's clinical record was reviewed on 12/4/13 at 10:07 A.M. The resident ' s diagnoses include, but were not limited to, hypertension, cerebral vascular accident with left sided weakness, benign prostatic hypertrophy with obstruction. The quarterly MDS (Minimum Data Set) dated 10/1/13, indicated his BIM 's score (Brief Interview Mental Status) score was 14 indicating resident was cognitively intact with a score of 13-15 being normal. Resident's functional status was indicated as extensive assist of 2 persons with bed mobility, hygiene and toilet use. Resident summary dated 11/27/13, indicated the resident required assist with bathing, dressing and was always incontinent with bowel and bladder. On 12/5/13 at 10:34 A.M., Resident		identifiedproblems. CQI evaluates the results of the plans as well. The CQICommittee meets monthly with the findings reported to the quarterly QualityAssurance Committee. (ADDENDUM: CNA TESTING ON PERINEAL CARE POLICY AND DIRECTOR OF NURSING MONITORING WILL BE ON-GOING).	

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	#15's care was provided by CNA # 2 and CNA # 3. As CNA# 2 and CNA# 3 with gloved hands were observed to remove the resident 's wedge positioning pillow from under his legs, a smear of brown substance was observed on the left side of the pillow where the resident 's legs had been positioned. That pillow was then placed on his chair next to his bed. After preparing a basin of soap and water, CNA #2 was observed to first cleanse, then rinse and dry the resident 's perineum area, each time in a circular motion beginning on the left side of the scrotum, under the scrotum and up the right side of the scrotum. Next, CNA #3 rolled resident onto his left side facing her. After hand washing and donning a new pair of gloves, CNA #2 proceeded to remove new washcloth from basin of same water previously used and cleansed the resident ' s buttocks. She was observed to cleanse a smear of brown substance from the resident 's left upper leg. At that same time during an interview, CNA # 2 indicated that area was dried BM (bowel movement). CNA# 2 was then observed to remove her gloves, washed her hands for 10 seconds, turn the faucet off with her wet hands, and then dried her hands. CNA #2 donned new gloves she assisted			

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	Resident #15 onto his right side. The resident was observed to have dried brown substance on both calves and left thigh. CNA #3 was observed to remove the soiled pads from under resident, return him to a supine position (laying on his back and covered resident with his sheet). At that time during an interview, CNA # 3 indicated she had not seen the dried BM on the resident's legs. CNA #2 proceeded to clean the areas of dried BM. On 12/5/13 at 11:17 A.M., during an interview CNA #3 indicated when doing peri -care for males, one should first clean the head of the penis followed by the shaft and finally the scrotal area. On 12/5/13 at 11:26 A.M., during an interview CNA #2 indicated if linens were dropped, they would be placed in dirty linen hamper and she would get clean ones. The " Incontinent briefs/care " policy was provided by the ADON on 12/5/13 at 12:30 P.M., the current policy indicated no specific procedure for care of male resident with incontinence. The "Indiana Nurse Aide Curriculum			

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	" , updated 12/4/13 indicated in appendix A, procedure 33 starting at step #23 indicates proper technique for perineal care of male residents included to wipe from front to back and from center of perineum to thighs. Change water in basin, wash hands and don new gloves to rinse and dry resident in same direction. For male procedure includes "...pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning with urethra. B. Continue washing down the penis to the scrotum and inner thighs...." 3.1-38(a)(3)(A)			

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F000322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.			
	Based on observation, interview and record review, the facility failed to follow their policy and procedure for medications administered through a g-tube, in that the placement of the g-tube was not checked prior to administering medication through it for 1 of 1 resident observed for g-tube medication administration. Resident #26 Findings include: During an observation of g-tube medication administration on 12/4/13 at 10:15 A.M., LPN #3 placed one Folic Acid 1 mg tablet, one Donepezil 5 mg tablet and one Aspirin 325 mg tablet in a paper medication cup and	F000322	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED: The Director of Nursing assessed Resident #26 and determined there were no adverse effects from LPN #3's failure to check for placement prior to administering medication through a g-tube. IDENTIFICATION OF RESIDENTS HAVING THEPOTENTIAL TO BE AFFECTED: The Director of Nursing identified residents with a naso-gastric or gastrostomy tube as having a potential to be affected by this practice. The Director of Nursing in-serviced LPN#3 (12/4/13) on facility "Gastric Tube Administration of Medication Policy". (Exhibit 4) MEASURES OR SYSTEMIC CHANGES TO	01/08/2014

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	crushed the tablets with a pair of pliers. LPN #3 poured the partially crushed medication into a plastic medication administration cup, then poured 10cc of water in the plastic cup and swirled it around several times. The plastic cup was observed to have pieces of the medication floating on top of the water. LPN #3 then poured 30 cc of unit-stat into a plastic medication cup, 15 cc of Centamin into a plastic medication cup, and 30 cc of water into a plastic medication cup. Upon entering Resident #26's room, LPN #3 placed the medication on the bedside table, went into the bathroom and washed her hands, donned gloves and returned to the recliner where Resident #26 was sitting. LPN #3 explained to Resident #26 she was going to administer medications. LPN #3 attached an extension tube to the Mic-Key g-tube (a low profile g-tube that is level with the skin) located in the center of Resident #26's abdominal area and a 60 cc syringe to the end of the extension tubing. Without aspiration or auscultation (i.e., listening to the internal sounds of the body with the use of a stethoscope) to check the placement of the G-Tube (aspiration of gastric content implies the tube is patent and		PREVENTREOCCURRENCES: Facility revised "Gastric-Tube Administration of Medication Policy" (Exhibit 4) (12/23/13). The revised policy requires two nurses present when proper placement of G-tube is checked by the nurse administering the medications. The In-Service Coordinator will in-service all nurses on the revised policy by 1/8/14 (Exhibit 5).The In-Service Coordinator will skill test all nursing staff regarding their knowledge and proficiency in performing the facility "Gastric-tube Administration Policy" by 1/8/14 (Exhibit 5). The nurses unable to successfully pass the skill testing will be relieved of duties associated with the administration of medication through a g-tube until they have successfully passed the skills test. The In-Service Coordinator will review Medication Administration Records monthly, to ensure that two nurses initial the Medication Administration Record to indicate placement of the g-tube is checked prior to administration of medications. The In-Service Coordinator will skills test nurses bi-annually and during orientation for newly hired nurses. CORRECTIVE ACTION MONITORED: The In-Service Coordinator will report monthly Medication Administration Records audits to the Director of Nursing and The Continuous Quality Improvement Committee	

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	in the stomach; auscultation with a stethoscope to hear air bubbling while 30 cc of air is injected into the g-tube implies the tube is patent and in the stomach). LPN #3 poured the partially crushed medication into the 60 cc syringe. The medication and water in the medication cup did not flow through the extension tubing. LPN #3 pinched the tubing and swirled the syringe several times. At that time, LPN #3 turned and indicated she had not checked placement of the G-Tube by way of aspiration or auscultation, but she indicated she had done so earlier that same the morning. LPN #3 indicated she had forgotten her stethoscope which she had left on the medication cart. When the content did not flow, LPN#3 then poured 15 cc of Centamin medication into the syringe and continued to pinch the tubing. LPN #3 then poured 5 cc of water into the syringe and pinched the tubing repeatedly and the medication began to flow. LPN #3 poured the 30 cc of Uni-Stat into the syringe and followed with 25 cc of water for the flush. During an interview with LPN #3 on 12/4/13 at 10:32 A.M., LPN #3		(CQI)The In-Service Coordinator will report the results of skill-testing regarding proper g-tube placement procedure bi-annually to the Director of Nursing and the facility Continuous Quality Improvement Committee (CQI).The role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. (ADDENDUM: MONTHLY MEDICATION ADMINISTRATION RECORD AUDITS AND BI-ANNUAL NURSES SKILLS-TESTING WILL BE ON-GOING).	

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	indicated she did not like to use the Silent Night Pill Crusher provided by the facility because the pill crusher left too much medication in the plastic pouches. She indicated that she preferred to use pliers to crush the medications thoroughly. LPN #3 indicated that she had checked placement earlier, but probably should have checked it again before giving the medication. LPN #3 said, "Look, I left my stethoscope here on the med cart." The facility's policy and procedure for Gastric Tube Administration of Medication was provided by the ADON and was reviewed on 12/4/13 at 11:00 A.M. and it read as follows: "3. Proper placement of tube will be checked prior to administering medication. 4. If placement cannot be verified - hold medication and notify physician. 5. Flush tube with prescribed amount of water before and after administration of medication." The clinical record of Resident #26 was reviewed on 12/4/13 at 11:10 A.M. The record indicated the diagnoses of Resident #26 included, but were not limited to, anxiety, neurogenic bladder, cerebral vascular accident, major depressive disorder,			

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	dysphagia. The November 2013 Physician's order read as follows: "Folic Acid 1 mg tab 1 tablet per peg every day." "Aspirin 325 mg one tablet per peg every day." "Donepezil HCL 5 Mg...1 tablet peg per every day "Centamin liquid 15cc per peg every day." "Uni-Stat 30 cc per tube twice daily for UTI prevention." "1/25/13 Diet: 30cc H2O flush after meds." During an interview with the Director of Nursing (ADON) on 12/4/13 at 12:00 P.M., the ADON indicated that when administering medication through a g-tube, placement should be checked before administering the medication. 3.1-44(a)(2)			

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. 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. Based on observation, interview, and record review, the facility failed to ensure timely disposal of medications with shortened expiration dates for 2	F000431	CORECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED: The Director of Nursing determined there were no adverse affects from the 2	01/08/2014

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	of 6 Advair Diskus (corticosteriod bronchodilator) medications observed in 1 of 3 medication carts observed. Findings include: On 12/4/13 at 3:25 P.M., the medication cart on hall one was observed with 2 opened Advair Diskus. The open dates were 10/5/13 for one, and the second was dated 10/19/13. On 12/4/13 at 3:38 P.M., during an interview with LPN #20, she indicated medication's would expire according to manufacturer's instructions. On 12/5/13 at 9:00 A.M., the Director of Nursing (DON) provided the medication storage policy. The current policy indicated, " Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier." On 12/5/13 at 9:35 A.M., the manufacturers instructions for an Advair Diskus was provided by the DON. These instructions indicated, "Safely discard Advair Diskus 1 month after you remove it from the foil pouch, or after the dose indicator reads 0, whichever comes first".		Advair Diskus medications that were not destroyed timely. The 2 expired Advair Diskus were destroyed and new medications ordered (12/4/13). IDENTIFICATIONOF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: The Director of Nursing identified residents with physician orders for the Advair Diskus as having the potential to be affected. The Director of Nursing in-serviced nurses responsible for administering the Advair Diskus medication (12/12/13) on the manufacturers recommendations (Exhibit 6). All Advair Discus medications were inspected to assure the shortened expiration dates were within the manufacturers recommendations. MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCES: The In-Service Coordinator will in-service all nurses monthly regarding the manufactures recommendation (Exhibit 6) on Advair Diskus medications with shortened expiration dates. The Director of Nursing will inspect Advair Diskus medications monthly to insure timely disposal of expired medications. The Pharmacy Consultant will inspect Advair Diskus medications monthly to ensure timely disposal of expired medications. CORRECTIVE ACTION MONITORED: The Director of Nursing will report	

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	On 12/5/13 at 10:02 A.M., during an interview DON, the DON indicated the pharmacist indicated Advair Diskus expired 30 days after removing the medication from its original foil. 3.1-25(o)		results of in-services, monthly medication inspections and monthly pharmacy inspections to the facility Continuous Quality Improvement Committee(CQI).The role of the CQI Committee(per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the Quarterly Quality Assurance Committee. Quality Assurance Committee. (ADDENDUM: THE MONTHLY IN-SERVICES AND MONTHLY INSPECTIONS TO ENSURE TIMELY DISPOSAL OF EXPIRED MEDICATIONS WILL BE ON-GOING).	

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on observation, interview,	F000441	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO HAVE	01/08/2014

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	and record review, the facility failed to ensure that the staff was performing proper handwashing when providing care to residents for 2 of 2 residents who were unable to carry out ADLs , which required extensive or partial assistance with personal hygiene. Resident #10, Resident #15 B. Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were followed and/or hand washing was done properly and timely for 2 of 2 noon dining room observations, and/ or distributions of personal laundry. Findings include: A.1. On 12/4/13 at 2:32 P.M., Resident #10's personal care was observed. In preparation CNA #4 was observed to hand wash for 15 seconds and CNA #2 for 10 seconds. At that same time during interview with CNA #2, she indicated the resident had been incontinent of urine. Both CNAs donned a pair of gloves. Resident #10 was repositioned and incontinent pad was removed. After removing their gloves, CNA #2 was observed to hand wash for 10 seconds. CNA #4 was observed to hand wash for 16		BEEN AFFECTED:A1./A2. The Infection ControlNurse assessed residents #10 and #15 and determined through assessment and record review there were no adverse affects from improper hand washing on the part of CNA# 2 and CNA# 3 during perineal care.B1. The Infection Control Nurse reviewed "Weekly Infection Control Report" (Exhibit 7)and determined there were no adverse affects on Hall 2 residents resulting from uncovered personal laundry delivered by Housekeeper #1.B3, 4, 5, 6, 7, 8, 9,10. The Infection Control Nurse reviewed "Weekly Infection Control Report" (Exhibit 7) and determined there were no adverse affects on residents eating in the Main Dining Room on 12/2/13, 12/4/2013 and12/5/2013.IDENTIFICATION OF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: The Infection Control Nurse identified those having the potential to be affected as residents requiring assistance with perineal care, residents residing on Hall 2 and residents eating in the Main Dining Room. The In-Service Coordinator in-serviced CNA# 2, CNA# 3, CNA# 20, CNA# 22, LPN# 21, and RN# 10 on facility "Hand Washing & Hand Asepsis Policy" (Exhibit 8) (12/5/13). The Housekeeping Supervisor in-serviced Housekeeper #1 on the necessity of covering	

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	seconds. CNA #2 was observed to wash the resident 's buttocks with the washcloth first. Then using same soap and water the resident 's peri-area was cleansed. After CNA # 2 cleaned Resident #10's peri-area she was observed to pour the basin of water down the sink. Both CNA,'s were observed to hand wash for 12 seconds. On 12/5/13 at 3:08 P.M., during interview employee LPN #21 indicated hand washing should be 15-20 seconds and with hand gel 15 seconds . On 12/5/13 at 3:00 P.M., during an interview, the Administrator and RN #11 indicated hand washing should be performed for 20 seconds. Resident #10 's clinical record was review on 12/5/2013 at 9:00 A.M., diagnoses included, but were not limited to: dementia and depression. On the 10/15/2013 quarterly MDS (Minimum Data Set) indicated Resident #10 required extensive assistance (two person) for toileting and personal hygiene. Resident #10 was frequently incontinent of urine (more than 7 episodes) and frequently incontinent of bowel (more		personal laundry during distribution (12/5/13).MEASURES OF SYSTEMIC CHANGES TO PREVENT REOCCURRENCES: The In-Service Coordinator will in-service CNA's and Nurses monthly on facility "Hand Washing& Hand Asepsis Policy" (Exhibit 8). These in-services will be followed by a written exam. CNA's and Nurses must pass the written exam each month. Staff unable to pass the written exam after three attempts will be suspended until a successful exam is achieved. The results of the written exams will be reported to the Infection Control Nurse. Clocks (equipped with second hands) will be placed in all residents' bathrooms and near Main Dining Room sink. This will enable all staff members to accurately determine the necessary 20 seconds required to correctly wash hands. The Housekeeping Supervisor will in-service all housekeeping staff regarding the necessity to cover personal linens during their distribution to Residents' rooms (12/12/13). The facility will purchase a laundry cart with a permanent cover (Exhibit 9). The housekeeping staff will be in-serviced on the proper use of this cart (1/8/2014).CORRECTIVE ACTION MONITORED: The infection Control Nurse will monitor results of written exams regarding facility "Hand Washing	

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	than 2 episodes) according to the MDS. A. 2. On 12/5/13 at 10:34 A.M., Resident #15's personal care was observed. As CNA #2 and CNA #3 with gloved hands were observed to remove the resident's wedge positioning pillow from under his legs, a smear of brown substance was observed on the left side of the pillow where the resident 's left leg had been positioned. The pillow was then placed on his chair next to his bed. After preparing a basin of soap and water, CNA #2 was observed to first cleanse, rinse and then dry the resident 's perineal area each time in a circular motion beginning on the left side of the scrotum, under the scrotum and up the right side of the scrotum. Next, CNA #3 rolled the resident onto his left side facing her. CNA #2 removed her gloves, washed her hands for 5 seconds, turned off the faucet with her wet hands before drying her hands. After donning new gloves, CNA #2 proceeded to remove new washcloth from the same basin of water.		and Hand Asepsis" (Exhibit 8) monthly. The Infection Control Nurse will report results of exams along with the results of the 'Weekly Infection Control Report' (Exhibit 7) to the facility Continuous Quality Improvement Committee(CQI).The role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. (ADDENDUM: THE MONTHLY IN-SERVICES AND MONTHLY EXAMS, MONITORED BY THE INFECTION CONTROL NURSE, WILL BE ON-GOING).	

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	B.1. On 12/4/13 at 12:09 P.M., Housekeeper #1 was observed passing personal laundry down 2nd hall on cart. No covering was observed over clean linens and the laundry cart. B.2. On 12/5/13 at 12:00 P.M., Housekeeping Supervisor indicated clean laundry was to be covered and delivered to resident's rooms. B.3. On 12/2/13 at 12:15 P.M. serving of trays in main dining room began. Lunch was observed being served. CNA #20 was observed to hand wash for 16 seconds after serving a tray to resident. At 12:16 P.M., RN #10 was observed to hand wash less than 10 seconds after serving tray to resident. CNA #3 was observed to hand wash for 10 seconds prior to serving food trays to residents. No hand gel was observed to be used. 4. On 12/2/13 at 12:23 P.M., the serving of the noon meal in the dining room was observed. RN #10 picked up the partially eaten cool whip dessert from Resident #34 and placed it on a counter in the main dining room without hand washing. She then continued to Resident #49 and opened paper packets of salt and sprinkled on Resident # 49's food.			

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	She then continued without hand washing to scoot/reposition Resident #55's dining room chair up closer to her table. RN #10 then did hand washing. 5. On 12/4/13 at 11:53 A.M. observation MDR (main dining room) staff beginning to bring residents to MDR. Hall one trays were distributed at 12:00 P.M. RN#10 was observed at 12:02 P.M., moving a resident and patting another resident on the hand and continued to serve trays without hand washing after touching a resident. 6. On 12/5/13 at 12:05 P.M., during observation of noon meal, observed LPN #21 washed her hands for 12 seconds, LPN #21 proceeded to assist serving noon meal. 7. On 12/5/13 during dining observation at 12:05 P.M. CNA # 2 was observed washing hands for 14 seconds then served a tray to a resident. LPN # 20 was observed to do a 10 second hand wash, then used hand gel and proceeded to serve tray. LPN # 21 was observed washing hands for 10 seconds then served tray. CNA # 3 was observed to wash her hands for 14 seconds, then serve a tray.			

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	8. On 12/5/13 at 12:13 P.M., during an observation of the noon meal, LPN #21 was observed to hand wash for 13 seconds, LPN #21 and then proceeded to assist serving the noon meal. 9. On 12/5/13 at 12:16 P.M., during observation of the noon meal, CNA #22 was observed to hand wash for 14 seconds. CNA #22 then proceeded to assist serving the noon meal. 10. On 12/5/13 at 3:08 P.M., during interview with LPN #21, she indicated hand washing was to be done for 15-20 sec under water and 15 sec with hand gel. 3.11-18(b)(l) 3.1-19(g)			

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. A. Based on observation, interview, and record review, the facility failed to ensure housekeeping and maintenance services were provided to maintain the facility in a sanitary condition in that a shower room located on 300 hall had mold like substance on the caulking around the base of the floor and on the grout located on the ceiling. This had the potential to impact 12 residents residing on 300 hall. B. Based on observation and interview, the facility failed to ensure floors, wall coverings, and/ or cove base were maintained in a sanitary condition for 3 of 3 hallways. Findings include: A. During the initial tour of the facility on 12/2/13 at 9:30 A.M., an operational shower room located on the 300 hall was observed to have a black, moldy looking substance located along the walls where the shower floor tiles met the base tile of the wall. The same black substance was also observed on the grout on	F000465	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:A. The Infection Control Nurse, through review of the "Weekly Infection Control Report" (Exhibit7) determined there were no adverse affects on the 12 residents on 300 Hall from the 300 Hall shower. The Infection Control Nurse through assessment determined there were no adverse affects on Resident #44 after using the shower on 300 Hall. B 1, 2 3, 4, 5. The Infection Control Nurse, through review of the "Weekly Infection Control Report" (Exhibit 7), determined there were no adverse affects on residents residing in rooms #2 and #7 due to cracked caulking around air conditioning units. The Infection Control Nurse, through review of the "Weekly Infection Control Report" (Exhibit 7) determined there were no adverse affectson residents residing in hallways #1, #2 and #3 due to brown and yellow discolored areas in the thresholds of residents' rooms and cracking cove base with black and brown substance. The Infection Control Nurse through review of the "Weekly Infection Control Report" (Exhibit 7)	01/08/2014

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	the ceiling of the shower room. During an interview with Resident #44 on 12/2/13 at 1:32 P.M., Resident #44 (who resided on 300 hall) indicated she had been given a shower that morning in the same shower room located on the 300 hall referenced in the preceding paragraph. The facility's policy and procedure for Floor Maintenance was reviewed on 12/5/13 at 4:00 P.M., and it read as follows: "showers...deep clean once a month with bleach." During an interview with the Housekeeping Supervisor (HKS) on 12/5/13 at 3:44 P.M., the HKS was made aware of the black, moldy looking substance on the ceiling and around the floor bases. At that time, the HKS indicated she routinely cleaned the shower room once a month, but added that she had missed the shower room cleaning routine the past couple of months. While looking at the ceiling and the floor the HKS said, "I see what you mean. I will clean it right away."		determined there were no adverse affects for Residents' on Hall #2 due to the peeling and torn wallpaper border. The Infection Control Nurse assessed the Resident in room #32 (this was actually room #34) and found no adverse affects from a soft spot in the flooring located in front of closet. IDENTIFICATION OF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: The Infection Control Nurse identified other Residents' residing on Halls #1, #2 and #3 as having a potential to be affected. Corrective actions taken by the Maintenance Supervisor included recaulking around air conditioning units in rooms #2 and #7. The Resident in #34 was relocated into another room while the Maintenance Supervisor repaired the flooring in front of the closet. A new floor stripping product will be used on Halls #1,#2 and #3. The floor stripping product will be used on the thresholds of residents' rooms and on the cove base located on Halls #1, #2, #3.The shower on 300 Hall was closed for repair of the grout and deep cleaning (12/2/13).MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCES:"The Housekeeping Worksheet" (Exhibit 10) will be revised to include a deep cleaning of shower rooms once per week. "The Weekly Maintenance	

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			Review" (Exhibit 11) will be revised to include inspections of all showers, the integrity of flooring in the resident rooms located on Halls #1,#2 and #3 and the appropriate seal surrounding resident air conditioning units. The In-Service Coordinator in-serviced Housekeeping and Maintenance on revised "Housekeeping Worksheet" (Exhibit 10) and "Weekly Maintenance Review" (Exhibit 11) (12/31/13). The wallpaper border will be removed from hall #2 and will not be replaced (1/8/14). The flooring and cove base on Halls #1, #2, #3 are over 19 years old. Discoloration and cracks are due tothe age of the flooring rather than the cleanliness of the facility. The facility has accepted a proposal (Exhibit12) to replace the flooring and cove base on Halls #1, #2 and #3.CORRECTIVE ACTIONS MONITORED: The Housekeeping Supervisor will review the "Housekeeping Worksheets" (Exhibit 10) and sign off on completed sheets weekly. The "Housekeeping Worksheets" will be submitted to the Administrator for review and signature. The Administrator will convey the results of the "Housekeeping Worksheets" to the monthly Continuous Quality Improvement Committee (CQI) The Maintenance Supervisor will complete the	

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			"Weekly Maintenance Review" (Exhibit 11) sign and date. The completed "Weekly Maintenance Review" will be submitted to the Administrator who will report the results to the monthly Continuous Quality Improvement Committee (CQI).The role of the CQI Committee(per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. (ADDENDUM: THE USE OF "HOUSEKEEPING WORKSHEETS" AND "WEEKLY MAINTENANCE REVIEW" WILL BE MONITORED BY THE ADMINISTRATOR AND WILL BE ON-GOING).REQUEST FOR WAIVER: I am requesting a 6 month waiver to complete the installation of the flooring and cove base on Halls #1, #2 and #3. This time will allow for the material, which is an imported special order, and for the	

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			scheduling of contracted services responsible for installation. I have been unable to secure assurances from the vendor or contractors for delivery of the special order items or the installation of those items by 1/8/2014.	
	B. On 12/5/13 at 9:20 A.M., during an environmental tour with MS (maintenance supervisor) and housekeeping supervisor the following was observed: 1. Caulking around air conditioning unit in room 2 and room 7 was cracked, daylight could be seen around unit, cold air felt entering through the area. 2. Flooring on hallways 1, 2 and 3 observed to have brown and yellow discoloration extending down entire halls on both sides of hall. Areas in the thresholds of resident's rooms observed to have large amount of brown build up particularly in corners. 3. Cove base (baseboard) on hallways 1, 2 and 3 was observed to be cracking and had black and brown substance on them. 4. Wall paper border on hall 2 was peeling and torn.			

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	5. In room 32, the floor in front of the closet was found to be soft and sunk down as if subflooring had a hole. At the same time during an interview, the maintenance supervisor indicated that his department was getting ready to winterize air conditioning units and would begin fixing flooring in room 32 and that flooring on all hallways had been stripped professionally in November. 12/5/13 12:00 P.M., during an interview with Housekeeping Supervisor, she provided a letter from a company used to strip floors and would be trying a new process after finding out if it would be safe for use around residents with respiratory issues. 3.1-19(f)			