

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155493	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
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NAME OF PROVIDER OR SUPPLIER SCENIC HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 311 E FIRST ST FERDINAND, IN 47532
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F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: April 9, 10, 14, 15, & 16, 2014.</p> <p>Facility number: 000534 Provider number: 155493 AIM number: 100267220</p> <p>Survey team: Terri Walters RN TC Dorothy Watts RN Amy Winger RN Sylvia Martin RN</p> <p>Census bed type: SNF: 7 SNF/NF: 70 Total: 77</p> <p>Census payor type: Medicare: 9 Medicaid: 36 Other: 32 Total: 77</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 21, 2014, by Jodi Meyer, RN</p>	F000000	<p>Scenic Hills has submitted the plan of correction and is asking for paper compliance as all areas noted in 2567 have been rectified and are in accordance to State and Federal Guidelines.</p> <p>The submission of this plan of correction does not indicate an admission by Scenic Hills Care Center that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Scenic Hills Care Center. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.</p> <p>The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	
F000160 SS=D	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on interview, and record review, the facility failed to refund the remaining balance in a resident trust account to the family within 30 days following a death for 1 of 3 accounts reviewed. (Resident #114)</p> <p>Findings include:</p> <p>On 4/15/14 at 1:55 P.M., a resident trust account statement was reviewed. A check for the remaining funds for Resident #114 had been sent to the family on 1/31/14.</p> <p>On 4/15/14 at 2:05 P.M., during an interview, the Business Office Manager (BOM) indicated Resident #114 had expired on 12/8/13. She also indicated it was the facility policy to send any funds remaining in a deceased resident's trust account within 30 days to the person administering the resident's estate.</p> <p>The BOM provided the facility policy for resident trust funds on 4/16/14 at 9:53A.M., it included, "...The campus will return the remaining resident funds with an accounting to the person administering the resident's estate within 30 days if the resident should expire or discharge..." 3.1-6(h)</p>	F000160	<p>F 160</p> <p>Resident # 114 no longer resides at the campus. All resident trust accounts have been audited. There we no other residents affected by practice. Completion Date 5-15-2014</p> <p>All other residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's Completion Date 5-15-2014</p> <p>Business office staff have been in serviced on the policy concerning resident trust.</p> <p>Systemic change: The AP/Payroll will be the back up to the BOM when she is away from the facility to ensure timely refunds. Completion Date 5-15-2014</p>	05/15/2014

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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>A. Based on observation, interview, and record review, the facility failed to ensure safety interventions were provided according to the plan of care, in that, safety equipment was not functioning properly and/or was not provided and the resident experienced falls (Resident #34) and interventions related toileting needs were not provided according to the care plan and the resident experienced 5 falls (Resident #106) for 2 of 14 residents in the Stage 2 sample.</p> <p>B. Based on observation, interview, and record review the facility failed to ensure care was provided according to the plan of care, in that, a resident was not toileted and/or repositioned according to the care plan (Resident #43) for 1 of 14 resident in the Stage 2 sample.</p> <p>Findings include:</p>	F000282	<p>ED/designee will review resident trust weekly x 1 month then every other week x 1 month then monthly to ensure policy followed with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 5-15-2014</p> <p>F 282</p> <p>Resident # 34, #43, and #106 plan of care has been reviewed and updated as appropriate. The alarm has been replaced by Plant Operations Director secured to the bathroom door.</p> <p>Completion Date 5-15-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in-servicing will ensure services provided by the campus are executed by qualified persons in accordance with each resident's written plan of care.</p>	05/15/2014

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	<p>A. 1. The clinical record for Resident #34 was reviewed on 04/14/14 at 2:30 P.M. Resident #34 was admitted to the facility on 9/22/11. The clinical record indicated the diagnoses for Resident #34 included, but were not limited to, cerebral vascular accident with left hemiplegia, and Parkinsons.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/19/14 indicated Resident #34 experienced mild cognitive impairment and needed the extensive assistance of 2 people with toileting, personal hygiene and transferring.</p> <p>A Individual Plan Report for Resident #34 dated 3/18/14 read as follows: "...ADL's...3/18/14 I may be at risk for falls - please see falls care plan on chart..."</p> <p>A Care Plan for falls dated 03/18/14 read as follows: "...bed & chair alarms - check functioning every shift...motion sensor alarm to 300 hall/shower room door..."</p> <p>The " Fall Circumstance and Assessment" forms indicated Resident #34 fell on the following days:</p> <p>Fall # 1 occurred on 2/14/14 at 1900 (7:00 P.M.). Resident #34 fell while transferring self to the toilet with no injuries. A chair alarm sounded, but was difficult to hear through 2 closed doors. A Change in Condition Form dated 2/14/14 at 1900 (7:00 P.M.) read as follows: "Resident attempted to toilet self. Alarm sounded but staff unable to reach resident before she fell..."</p> <p>Fall #2 occurred on 2/18/14 at 0100 (1:00 A.M.). Resident #34 was in the common</p>		<p>Completion Date 5-15-2014</p> <p>Nursing staff in-serviced on importance of following plan of care along with its implementation and the new nurse aide assignment sheets for increased accessibility. All resident care plans have been reviewed and revised as appropriate by the Director of Nursing. All residents Alarm Care Plans will be reviewed by the Director of Nursing and updated as necessary.</p> <p>Completion Date 5-15-2014</p> <p>Systemic change is the C.N.A. assignment sheets will be implemented to allow clear communication and assurance of individual plans of care.</p> <p>Completion Date 5-15-2014</p> <p>DHS/designee to audit three random residents to assure nursing staff following plan of care 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion Date 5-15-2014</p>	

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	<p>area folding blankets and had an increase in agitation and confusion resulting in her sliding out of her wheelchair. A Nurse's note dated 2/18/14 at 0130 (1:30 A.M.) read as follows: "...CNA reported that alarm was sounding but staff were unable to reach resident prior to sliding on floor."</p> <p>Fall #3 occurred on 3/14/14 at 0145 (1:45 A.M.). Resident #34 was in her room and rolled out of bed. A Nurse's note dated 3/14/14 dated 0415 (4:15 A.M.) read as follows: "CNA responded to resident's alarm sounding. Resident up from bed states,"going to restroom". Got to end of bed CNA seen her falling backwards as she went into room..."</p> <p>Fall #4 occurred on 3/21/14 at 0110 (1:10 A.M.). Resident #34 was in her room and rolled out of bed. Injuries to her left forehead and top right hand were noted. A Nurse's note dated 3/21/14 at 0110 (1:10 A.M.) read as follows: "Resident found on floor in front of BR.(bathroom) door...tried walking to restroom per self ... Alarm did not sound on inspection cord of alarm loose in socket not staying plugged in very well. Pad alarm changed..."</p> <p>During an interview on 4/16/14 at 9:15 A.M., CNA #13 indicated she did not know whether a motion sensor alarm was positioned on the 300 hall shower room door. CNA #13 indicated that no one had informed her whether the motion sensor alarm on the 300 hall shower room door had been discontinued or not. CNA #13 further indicated she had not seen the motion sensor detector on the shower room door on the 300 hall in awhile. CNA #13 then walked into the shower room bathroom where she pointed to the frame of the door and said, "It used to be</p>			

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	<p>here, but now the velcro is gone, and the alarm is not there." CNA #13 indicated she had not seen the Falls Care Plan and did not know where to find it.</p> <p>During an interview with on 4/16/14 at 10:10 A.M., the Director of Nursing (DON) indicated an alarm should be on the door to ensure that Resident #34 would not be able to enter the shower room to use the bathroom without sounding the alarm.</p> <p>B. 1. During a random observation on 4/10/14 at 3:54 P.M., CNA #13 lifted Resident #43 up from her chair to take her to the bathroom. The entire back side of her red pants were observed to be wet as were the front of her pants. The recliner Resident #43 had been sitting on was observed to be wet, and the houskeeping staff was observed, at that time, to remove the chair from the unit. During an interview, at that time, CNA #12 indicated the chair was being removed from the unit for thorough cleaning due to urine soilage.</p> <p>During continuous observation on 4/14/14 from 8:36 A.M. through 11:45 A.M., Resident #43 was not repositioned or toileted. Resident #43 was observed to be taken from her chair to the dining room for lunch and seated at the table. Resident #43 was not toileted before a lunch meal.</p> <p>During continuous observation on 4/14/14 from 2:10 P.M. through 4:45 P.M., Resident #43 was not repositioned or toileted. Resident #43 was observed to be taken from her chair to the dining room for supper. Resident #43 was not toileted before the supper meal.</p>			

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	<p>During an observation of care on 04/15/14 at 9:58 A.M., an area of skin impairment was observed on the right buttock of Resident #43.</p> <p>The clinical record for Resident #43 was reviewed on 4/14/14 at 2:30 P.M. The record indicated the diagnoses of Resident #43 included, but were not limited to, dementia, Parkinson, atrial fib.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/17/14 indicated Resident #43 experienced severe cognitive impairment and needed the extensive assistance of 2 staff members when transferring and toileting.</p> <p>A Care Plan for skin impairment dated 02/13/14 read as follows: "...I am at risk for skin impairment since I am not as mobile as I was in the past, I am incontinent, and my dementia does not allow me to recognize and express what I am thinking and feeling. I do not want to develop any pressure areas. ...Please make sure I change my position every 2 hours..."</p> <p>During an interview on 4/16/14 at 9:10 A.M., CNA #13 indicated Resident #43 should be toileted and repositioned every 2 hours as directed by Resident #43's care plan.</p> <p>3.1-35(f) 3.1-35(l)(2) 3.1-35 (g)(2)</p> <p>2. Resident #106 was observed on 04/09/14 at 1:17 P.M., sitting in a wheelchair in the</p>						

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	<p>resident's room.</p> <p>During an interview on 04/10/14 at 11:00 A.M., RN #2 indicated Resident #106 had experienced falls since being admitted to the facility.</p> <p>The clinical record of Resident #106 was reviewed on 04/14/14 at 2:20 P.M. The record indicated the diagnoses of Resident #106 included, but were not limited to, chronic renal failure.</p> <p>The "Nursing Admission Assessment and Data Collection" form dated 01/04/14 indicated, "Elimination...occasionally incontinent r/t (related to) not able to get to urinal in time r/t diuretics...usual voiding pattern: ...no pattern able to be established...Safety...history of falls, requires assistance to transfer, requires assistance to ambulate...has disease or condition that predisposes to fall..."</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 01/11/14 indicated Resident #106 was admitted on 01/04/2014 with a primary diagnosis of falls, experienced occasional episodes of urinary incontinence and a toileting program was not being used to manage urinary incontinence.</p> <p>An "Assessment Review and Considerations" dated 01/17/14 indicated, "...Fall risk: This resident has the following risk factors that may contribute to falls: ...incontinence...Incontinent at times r/t not able to get to toliet (sic) /urinal in time...Assessment considerations...An individualized care plan/toileting plan has been initiated to address the above risk factors and minimize the risk of</p>			

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	<p>incontinence..."</p> <p>A Plan of Care for Bowel and Bladder dated 01/22/14 indicated, "...Toilet me upon rising, before and after meals, hs (hour of sleep) and prn (as needed)..." The Plan of Care lacked any interventions related to scheduled toileting between the hour of sleep and upon rising.</p> <p>A Plan of Care for Falls dated 01/22/14 indicated, "At risk for fall/injury AEB (as evidenced by) history of falls, potential for fall with an intervention dated 03/27/14 of "toilet (sic) 10p (P.M.)-6a (A.M.) every 2 hours 6a-10p upon rising before/after meals at hs (hour of sleep) and prn (as needed)..."</p> <p>The " Fall Circumstance and Assessment Forms" indicated Resident #106 fell on the following days:</p> <p>Fall #1 occurred on 02/14/14 at 1420 (2:20 P.M.) in his room.</p> <p>Fall #2 occurred on 02/14/14 at 1700 (5:00 P.M.) in his room.</p> <p>Fall #3 occurred on 02/15/14 at 0445 (4:45 A.M.) in his room. The IDT review section of the form indicated new interventions of "toilet between 0300 (3:00 A.M.)-330 (3:30 A.M.)...offer urinal..."</p> <p>Fall #4 occurred on 03/26/14 at 1315 (1:15 P.M.) in his room.</p> <p>Fall #5 occurred on 03/28/14 at 0010 (12:10 A.M.), in his room. The IDT review section of the form indicated new interventions of "...10p-6a (A.M.)-toilet (sic) q (every) 2 (two) hours...6a-10p-toilet (sic) upon rising, before</p>			

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F000314 SS=D	<p>and after meals at hs and prn..."</p> <p>The Nurse's notes from 03/28/14 at 1:30 A.M. through 04/14/14 at 2:30 P.M. were reviewed and indicated Resident #106 had experienced no further falls after a toileting plan was initiated.</p> <p>During an interview on 04/15/14 at 10:00 A.M. the DON (Director of Nursing) indicated Resident #106 had been identified as a high risk to fall upon admission, had episodes of confusion, and no documentation could be provided to indicate a toileting plan had been initiated for Resident #106 until after the fall on 03/28/14.</p> <p>During an interview on 04/15/14 at 10:35 A.M. the DON indicated Resident #106 should have been toileted every two hours and further stated, at that time, "we knew the root cause of the falls was having to toilet, that was identified on admission..."</p> <p>The Policy and Procedure for "Falls Management Program Guidelines provided by the DON on 04/15/14 at 1:51 P.M. indicated, "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures..."</p> <p>3.1-35(f) 3.1-35 (g)(2) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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</p>				

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	<p>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 observation, interview and record review the facility failed to ensure a resident did not develop a pressure area and/or did not receive services to promote healing, in that, a resident admitted without skin impairment developed an area of pressure on the right buttock, the area was identified as an abrasion, and the resident did not receive pressure relief according to the care plan. (Resident #43)</p> <p>Findings include:</p> <p>On 4/15/14 at 1:35 P.M., Resident #43's wound area on right buttock was observed. The area located on Resident # 43's right buttock was half way down the intergluteal fold. LPN #2 measured the wound area on the right buttock as 1.8 cm length X 1.7 cm in width X 0.1 cm in depth. No drainage or slough was noted on wound bed. The measurements of the area as documented on the "Other Skin Impairment Assessment Form" indicated the wound was 1.8 cm length X 1.3 cm in width X 0.1 cm in depth on 4/10/14.</p> <p>Nurses' notes dated 4/15/14 1340 (3:30 P.M.), read as follows: "Area on coccyx remeasured d/t due date. It has increased sl (slightly) but only due to area flattening. Prev tx (previous treatment) left skin more hard and peeling. Area is more even surfaced...."</p>	F000314	<p>F314 Resident #43 wound is now healed. Completion Date 5-15-2014 All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in-servicing the campus will ensure measures to prevent sores and provide care for current pressure ulcers in accordance with physician's orders. Completion Date 5-15-2014 All nursing staff have been in serviced concerning: 1. Utilization of the assignment sheets. 2. Proper positioning and prevention techniques. All licensed staff have been in serviced on identification and assessment of skin impairments. The possibility of skin issues have been reviewed and updated as appropriate with the review of facility wide care plans by the Director of nursing. At risk residents have been reviewed upon care plan changes or updates as suitable. 100 hall reviewed 22% of all residents 200 hall 20%, 300 Hall, 24%, and 400 hall 20% had hands on review by Assistant Director of nursing. Completion Date 5-15-2014 Systemic changes as follows: 1. CNA assignment sheet to alert</p>	05/15/2014

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	<p>During an interview on 4/15/14 at 1:35 P.M., LPN #2 indicated the wound located on Resident #43's buttock was caused by shearing. LPN #2 further indicated she thought maybe the shearing happened when Resident #43 was being toileted.</p> <p>2. During an observation on 4/10/14 at 3:54 P.M., CNA #13 lifted Resident #43 up from her chair to take her to the bathroom. The entire back side of her red pants was observed to be wet as were the front of her pants. The recliner where Resident #43 had been sitting was observed to be wet, and the housekeeping staff removed the chair for cleaning.</p> <p>3. During a continuous observation on 4/14/14 from 8:36 A.M. through 11:45 A.M., Resident #43 was not repositioned or toileted. Resident #43 was observed to be taken from her chair to the dining room for lunch and seated at the table. Resident #43 was observed to not be toileted before the lunch meal.</p> <p>4. During a continuous observation on 4/14/14 from 2:10 P.M. through 4:45 P.M., Resident #43 was not repositioned or toileted. Resident #43 was observed to be taken from her chair to the dining room for supper. Resident #43 was observed to not be toileted before the supper meal.</p> <p>The clinical record for Resident #43 was reviewed on 4/14/14 at 2:30 P.M. The record indicated the diagnoses of Resident #43 included, but was not limited to, dementia, Parkinson, and atrial fib.</p> <p>The Admission MDS (Minimum Data Set</p>		<p>staff of pressure prevention interventions 2. ADHS/designee will review new skin impairments to assure assessed per NPUAP guidelines. Completion Date 5-15-2014 DHS/designee will complete a random audit on 3 different residents to assure pressure relief is provided per the care plan 5x/wk x one month, 3x/wk x one month the weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 5-15-2014</p>				

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	<p>Assessment) dated 03/17/14 indicated Resident #43 experienced severe cognitive impairment and needed the extensive assistance of 2 staff members when transferring and toileting.</p> <p>Physician's Order dated 4/01/14, read as follows: "...4/2/14 Calazime Paste to abrasion on R (right) upper Buttock near coccyx q (every) shift x (times) 7 days et (and) re eval (reevaluate)..."</p> <p>Physician's Order dated 4/10/14, "Desitin to abraded area q shift x 7 days et re eval"</p> <p>A Care Plan for skin impairment dated 02/13/14 read as follows: "...I am at risk for skin impairment since I am not as mobile as I was in the past, I am incontinent, and my dementia does not allow me to recognize and express what I am thinking and feeling. I do not want to develop any pressure areas. ...Please make sure I change my position every 2 hours..."</p> <p>"A Change of Condition Form" dated 3/25/14 for Resident #43 read as follows: "...Res has abrasion area on r upper buttock near coccyx measures 1.9 x 1.3cm with 0.4 cm diameter with open area in the center."</p> <p>During an interview on 4/15/14 at 10:15 A.M., the Assistant Director of Nursing (ADON) indicated the area on the right buttock was caused by shearing. The ADON further indicated that the wound on Resident #43's right buttock occurred while Resident #43 was being toileted.</p> <p>On 4/15/14 at 1:51 P.M., the Director of Nursing provided the facility's "Wound Staging and Identification Educational</p>			

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F000315 SS=D	<p>Information Form". It read as follows: "...8. Pressure ulcers as defined by the NPUAP is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and friction..."</p> <p>During an interview on 4/16/14 at 9:10 A.M., CNA #13 indicated Resident #43 needed to be toileted and repositioned every 2 hours as directed by Resident #43's care plan.</p> <p>3.1-40(a)(1) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident was toileted in a timely manner as evidenced by a resident exhibiting wet pants upon rising for 1 of 3 residents reviewed for urinary incontinence. (Resident #43)</p> <p>Findings include:</p> <p>1.. During an observation on 4/10/14 at 3:54 P.M., CNA #13 lifted Resident #43 up from her chair to take her to the bathroom. The</p>	F000315	F 315 Resident # 43 toileting plan has been reviewed and updated as needed. Completion Date 5-15-2014 All residents have the potential to be affected by the alleged deficient practice and therefore through corrective actions and in-servicing the campus will ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much bladder function as normal for each individual resident.	05/15/2014			

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	<p>entire back side of her red pants were observed to be wet as were the front of her pants. The recliner where Resident #43 had been sitting was observed to be wet, and the housekeeping staff removed the chair for cleaning.</p> <p>2.. During a continuous observation on 4/14/14 from 8:36 A.M. through 11:45 A.M., Resident #43 was not repositioned or toileted. Resident #43 was observed to be taken from her chair to the dining room for lunch and seated at the table. Resident #43 was not toileted before a lunch meal.</p> <p>3.. During a continuous observation on 4/14/14 from 2:10 P.M. through 4:45 P.M., Resident #43 was not repositioned or toileted. Resident #43 was observed to be taken from her chair to the dining room for supper. Resident #43 was not toileted before the supper meal.</p> <p>The clinical record for Resident #43 was reviewed on 4/14/14 at 2:30 P.M. The record indicated the diagnoses of Resident #43 included, but were not limited to, dementia, Parkinson, atrial fib.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/17/14 indicated Resident #43 experienced severe cognitive impairment and needed the extensive assistance of 2 staff members when transferring and toileting.</p> <p>A Care Plan for Bowel and Bladder dated 02/13/14 indicated, "...Incont (incontinent) at times wears pull ups size medium...TP(Toileting Program): upon rising before and after meals at HS and PRN...</p>		<p>Completion Date 5-15-2014 Nursing staff have been in-serviced on individual resident toileting plans. All residents have been reviewed for proper incontinent care and toileting plans by the Director of Nursing. Care plans have been revised and updated as individual needs indicate. Completion Date 5-15-2014 Systemic change is implementation of CNA assignment sheets to alert staff to individual toileting plans tailored to each resident need.</p> <p>Completion Date 5-15-2014 DHS and/or designee will monitor 3 random incontinent resident to assure the most effective toileting plan is implemented 5x a week x one month then 3x a week x one month then weekly thereafter with results forwarded to the QA committee for 6 months and quarterly thereafter for further review and suggestions/recommendations. Completion Date 5-15-2014</p>		

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F000323 SS=D	<p>A Care Plan for Mood and Behaviors dated 1/29/14 read as follows: "I have issues with being toileted but they are improving. At times if I am toileted before I am incontinent then I am more receptive to being toileted. Once I am incontinent I do not want to sit on the toilet and need much more assistance and encouragement but this is improving... Please explain procedure before beginning..."</p> <p>During an interview on 4/10/14 at 4:10 P.M., CNA #7 indicated she had just changed Resident #43's wet incontinent brief and pants.</p> <p>During an interview on 4/16/14 at 9:10 A.M., CNA #13 indicated Resident #43 was on a toileting program and needed to be toileted and repositioned every 2 hours as directed by Resident #43's care plan.</p> <p>3.1-41(a)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure effective safety interventions and/or supervision were provided (Resident #34), in that, effective interventions were not implemented for a resident identified as having impairment that effected safety and judgment, and/or difficulty understanding and following directions and the resident experienced 5 falls (Resident</p>	F000323	<p>F 323</p> <p>Resident #34 and #106 suffered no ill effects from the alleged deficiency.</p> <p>Completion Date 5-14-2014</p>	05/15/2014			

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	<p>#106) for 2 of 3 residents who met the criteria for review of falls.</p> <p>Findings include:</p> <p>1. On 4/14/14 Resident #34 was observed to be sitting in her recliner in the common area of the 300 unit from 8:31 A.M. to 11:35 A.M. On 4/14/14 at 2:30 P.M., Resident #34 was observed to be in the common area sitting in her wheelchair looking at a magazine.</p> <p>The clinical record for Resident #34 was reviewed on 04/14/14 at 2:30 P.M. Resident #34 was admitted to the facility on 9/22/11. The clinical record indicated the diagnoses for Resident #34 included, but were not limited to, diabetes, cerebral vascular accident with left hemiplegia, depression and Parkinson's.</p> <p>The "Fall Circumstance and Assessment" included in the chart indicated Resident #34 fell on the following days:</p> <p>Fall # 1 occurred on 2/14/14 at 1900 (7:00 P.M.). Resident #34 fell while transferring self to the toilet with no injuries. A chair alarm sounded, but was difficult to hear through 2 closed doors.</p> <p>Fall #2 occurred on 2/18/14 at 0100 (1:00 A.M.). Resident #34 was in the common area folding blankets and had an increase in agitation and confusion resulting in her sliding out of her wheelchair. No injuries were reported or recorded.</p> <p>Fall #3 occurred on 3/14/14 at 0145 (1:45 A.M.). Resident #34 was in her room and rolled out of bed. No injury reported or noted.</p>		<p>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Completion Date 5-14-2014</p> <p>Nursing staff have been in serviced concerning C.N.A. assignment sheets that include fall interventions. Systemic change is C.N.A are to carry assignment sheets to review interventions as needed. Campus will review entire medical record post fall to assure intervention effective. Interdisciplinary approach has been taken to help assess and identify residents to prevent accidents and fall risks, such as, pharmacological interventions which include a decrease, in one month, from 15 residents taking antipsychotic medication to 10 which is a 7.9 % overall facility rating. Initiate Physical and/or Occupational therapy services with changes of ADL's, and adjustments of care plans as individual needs change.</p> <p>Completion Date 5-14-2014</p>		

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	<p>Fall #4 occurred on 3/21/14 at 0110 (1:10 A.M.). Resident #34 was in her room and rolled out of bed. Injuries to her left forehead and top right hand were noted.</p> <p>A " Change in Condition Form" dated 2/14/14 at 1900 (7:00 P.M.) read as follows: "Resident attempted to toilet self. Alarm sounded but staff unable to reach resident before she fell..."</p> <p>A Nurse's note dated 2/18/14 at 0130 (1:30 A.M.) read as follows: "Res. (Resident) observed on floor in 300 wing common area by CNA (CNA's Name). CNA reported that alarm was sounding but staff were unable to reach resident prior to sliding on floor." A Nurse's note dated 3/14/14 dated 0415 (1:45 A.M.) read as follows: "CNA responded to resident's alarm sounding. Resident up from bed states,"going to restroom". Got to end of bed CNA seen her falling backwards as she went into room..."</p> <p>A Nurse's note dated 3/21/14 at 0110 (1:10 A.M.) read as follows: " Resident found on floor in front of BR.(bathroom) door at this time. She had tried walking to restroom per self lost balance. fell forward striking head on wall by B.R. door. She was laying on stomach. Alarm did not sound on inspection cord of alarm loose in socket not staying plugged in very well. Pad alarm changed..."</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/19/14 indicated Resident #34 experienced mild cognitive impairment and needed the extensive assistance of 2 people with toileting, personal hygiene and transferring.</p> <p>A undivided Plan Report for Resident #34 dated 3/18/14 read as follows: "...ADL's...3/18/14 I may be at risk for falls -</p>		<p>DHS /designee will monitor 3 random resident at risk for falls to assure safety interventions in place and interventions effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 5-14-2014</p>	

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	<p>please see falls care plan on chart..."</p> <p>A Care Plan for falls dated 03/18/14 read as follows: "...bed & chair alarms - check functioning every shift...motion sensor alarm to 300 hall/shower room door... "</p> <p>During an interview on 4/16/14 at 9:15 A.M., CNA #13 indicated she did not know whether a motion sensor alarm was positioned on the 300 hall shower room door. CNA #13 indicated that no one had informed her whether the motion sensor alarm on the 300 hall shower room door had been discontinued or not. CNA #13 further indicated she had not seen the motion sensor detector on the shower room door on the 300 hall in awhile. CNA #13 then walked into the shower room bathroom where she pointed to the frame of the door and said, "It used to be here, but now the Velcro is gone, and the alarm is not there." CNA #13 indicated she had not seen the Falls Care Plan and did not know where to find it.</p> <p>During an interview with on 4/16/14 at 10:10 A.M., the Director of Nursing (DON) indicated an alarm had been placed on the bathroom/shower door to ensure that Resident #34 would not be able to enter the shower room to use the bathroom without sounding the alarm. The DON was made aware the alarm was not positioned and that the CNA working on the unit did not know whether the alarm had been discontinued or not. The DON was informed that CNA #13 had looked for the alarm but was not able to locate the alarm for the door.</p> <p>2. Resident #106 was observed on 04/09/14</p>			

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	<p>at 1:17 P.M., sitting in a wheelchair with a chair alarm attached the frame of the wheelchair.</p> <p>During an interview on 04/10/14 at 11:00 A.M., RN #2 indicated Resident #106 had experienced falls since being admitted to the facility.</p> <p>The clinical record of Resident #106 was reviewed on 04/14/14 at 2:20 P.M. The record indicated the diagnoses of Resident #106 included, but were not limited to, chronic renal failure.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 01/11/14 indicated Resident #106 was admitted on 01/04/2014 with a primary diagnosis of falls, experienced minimal cognitive impairment, required the extensive assist of one staff for transfers, experienced unsteady balance during walking, experienced occasional episodes of urinary incontinence and a toileting program was not being used to manage urinary incontinence.</p> <p>The "Nursing Admission Assessment and Data Collection" form dated 01/04/14 indicated, "Elimination...occasionally incontinent r/t (related to) not able to get to urinal in time r/t diuretics...usual voiding pattern: ...no pattern able to be established...Safety...history of falls, requires assistance to transfer, requires assistance to ambulate...has disease or condition that predisposes to fall..."</p> <p>An "Assessment Review and Considerations" dated 01/17/14 indicated, "...Fall risk: This resident has the following risk factors that may contribute to falls: ...mobility</p>			

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	<p>impairment, past history...incontinence...Incontinent at times r/t not able to get to toilet (sic) /urinal in time...Assessment considerations...An individualized care plan/toileting plan has been initiated to address the above risk factors and minimize the risk of incontinence..."</p> <p>A Plan of Care for Cognition dated 01/07/14 indicated, "...I am having some episodes of confusion or mixing up details..."</p> <p>A Plan of Care for Bowel and Bladder dated 01/22/14 indicated, "...Toilet me upon rising, before and after meals, hs (hour of sleep) and prn (as needed)..." The Plan of Care lacked any interventions related to scheduled toileting between the hour of sleep and upon rising.</p> <p>A Plan of Care for Falls dated 01/22/14 indicated, "At risk for fall/injury AEB (as evidenced by) history of falls, potential for fall with an intervention dated 03/27/14 of "toilet (sic) 10p (P.M.)-6a (A.M.) every 2 hours 6a-10p upon rising before/after meals at hs (hour of sleep) and prn (as needed)..."</p> <p>Fall #1 A "Fall Circumstance Assessment and Intervention" form dated 02/14/14 indicated Resident #106 experienced a fall on that date at 1420 (2:20 P.M.) while, "... ambulating...assistive device not used...Fall Risk Re-Assessment... cognitive or memory impairment that effects safety and judgment, difficulty understanding and following directions...incontinent of bladder...at times..." The IDT (Interdisciplinary Team) review section of the form indicated new interventions of "encourage resident to use walker, keep in reach while in bed..."</p>			

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	<p>A Nursing note dated 02/14/14 at 1600 (4:00 P.M.) indicated, "Res. (resident) found sitting on the floor...as intervention, encourage and remind res to use walker when ambulating..."</p> <p>Fall #2 A" Fall Circumstance Assessment and Intervention" form dated 02/14/14 indicated Resident #106 experienced a fall on that date at 1700 (5:00 P.M.), "... found on floor...ambulating...assistive device not used...Fall Risk Re-Assessment... cognitive or memory impairment that effects safety and judgment, difficulty understanding and following directions...incontinent of bladder...at times..." The IDT review section of the form indicated new interventions of "bed and chair alarms X (times) 7 (seven) days..."</p> <p>A Nurse's note date 02/14/14 at 2300 (11:00 P.M.) indicated, "Res ambulating without walker in room...around 1700 and lost balance...will place bed and chair alarm for 7 days..."</p> <p>Fall #3 A" Fall Circumstance Assessment and Intervention" form dated 02/15/14 indicated Resident #106 experienced a fall on that date at 0445 (4:45 A.M.), "... ambulating...assistive device not used...assistive device at bedside et (and) in reach resident not using after reminders...Fall Risk Re-Assessment... cognitive or memory impairment that effects safety and judgment, difficulty understanding and following directions...incontinent of bladder...at times..." The IDT review section of the form indicated new interventions of "toilet between 0300 (3:00 A.M.)-330 (3:30 A.M.)...offer urinal..."</p> <p>A Nurse's note dated 02/15/14 at 0445</p>			

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	<p>indicated, "Residents alarm sounding et CNA entered room, resident up with walker became startled lost balance et fell backwards to butt...Immediate intervention is to toilet resident between 0300 et 0330 every morning..."</p> <p>Fall #4 A "Fall Circumstance Assessment and Intervention" form dated 03/26/14 indicated Resident #106 experienced a fall on that date at 1315 (1:15 P.M.), "... reaching for an object...Fall Risk Re-Assessment...cognitive or memory impairment that effects safety and judgment, difficulty understanding and following directions...incontinent of bladder..." The IDT review section of the form indicated new interventions of "reacher...keep items of interest in reach..."</p> <p>A Nurse's note dated 03/26/14 at 1400 (2:00 P.M.) indicated, "Res. leaned forward to reach for item at bedside et slid out of w/c (wheelchair)...Nsg (Nursing) intervention for res to have reacher at bedside..."</p> <p>Fall #5 A "Fall Circumstance Assessment and Intervention" form dated 03/28/14 indicated Resident #106 experienced a fall on that date at 0010 (12:10 A.M.), "...toileting...Fall Risk Re-Assessment...cognitive or memory impairment that effects safety and judgment,..." The IDT review section of the form indicated new interventions of "...10p-6a (A.M.)-toilet (sic) q (every) 2 (two) hours...6a-10p-toilet (sic) upon rising, before and after meals at hs and prn..."</p> <p>A Nurse's note dated 03/28/14 at 0010 indicated, "...Alarm sounded...entered room within 2 seconds to see res between bed and</p>			

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F000371 SS=F	<p>wall in a squatting position...stated...was going to bathroom...ask resident why ...not call for help...stated 'I don't know'...instructed staff to wake resident and ask...needs to toilet at least Q2H (every two hours) through the night..."</p> <p>The Nurse's notes from 03/28/14 at 1:30 A.M. through 04/14/14 at 2:30 P.M. were reviewed and indicated Resident #106 had experienced no further falls after a toileting plan was initiated.</p> <p>During an interview on 04/15/14 at 10:00 A.M. the DON (Director of Nursing) indicated Resident #106 had been identified as a high risk to fall upon admission, had episodes of confusion, and no documentation could be provided to indicate a toileting plan had been initiated for Resident #106 until after the fall on 03/28/14.</p> <p>During an interview on 04/15/14 at 10:35 A.M. the DON indicated Resident #106 should have been toileted every two hours and further stated, at that time, "we knew the root cause of the falls was having to toilet, that was identified on admission..."</p> <p>The Policy and Procedure for "Falls Management Program Guidelines provided by the DON on 04/15/14 at 1:51 P.M. indicated, "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures..."</p> <p>3.1-45(a)(2) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or</p>				

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	<p>considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review the facility failed to ensure kitchen equipment was clean and food was prepared and/or served under sanitary conditions in that, kitchen staff did not have hair completely contained within a cap, the stove burners contained black debris, and the ceiling above the food serving area had peeling paint. This had the potential to affect 77/77 residents who resided in the building.</p> <p>Findings include:</p> <p>The following was observed on 04/09/14 at 10:00 A..M.:</p> <ol style="list-style-type: none"> 1. The CDM (Certified Dietary Manager) was observed to have hair extruding from the sides and back of a baseball cap. 2. The stove top and burner area were observed to be soiled with black debris. 3. The ceiling above the serving area was observed to have peeling paint. <p>The following was observed on 04/14/14 at 9:30 A.M.:</p> <ol style="list-style-type: none"> 4. The CDM and CA (Cook Assistant) #2 were observed to have hair extruding from the sides and back of a baseball cap. 5. The stove top and burner area were observed to be soiled with black debris. 	F000371	<p>F371</p> <p>Residents did not suffered ill effects from alleged deficient practice.</p> <p>Completion Date 5/15/14</p> <p>All residents have the potential to be affected by the alleged practice and through alterations, processes, and in-servicing the campus will ensure food is prepared and distributed under sanitary conditions. The chipped paint has been patched and repaired by Plant Operations Director, burners cleaned by Director of Food Service, and hair contained by updated hair restraint policy.</p> <p>Completion Date 5/15/14</p> <p>In service all dietary staff concerning new hair restraint policy, inspection of stove burners, and identification of repair needs such as the ceiling in or near food service & preparation area. In service Plant Operation Director of proper recognition, monitoring, and repair of ceiling in or near food service and preparation area.</p>	05/15/2014

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	<p>During an interview, at that time, the CDM indicated, the debris was burned food and grime. The CDM, further indicated, the stove be thoroughly cleaned when soiled.</p> <p>6. The ceiling above the serving area was observed to have peeling paint. During an interview, at that time, Cook #1 indicated the steam from the steam table had caused the paint to peel in the past and the maintenance man would fix it.</p> <p>During an interview on 04/14/14 at 4:00 P.M. the HFA (Health Facilities Administrator) indicated the dietary staff should have hair completely contained, the stove should be clean, and the paint should not be peeling over the food serving area.</p> <p>The "Dietary Hair Restraint Policy and Procedures" provided by the HFA on 04/14/14 at 2:00 P.M. indicated, "...has chosen baseball...caps...for out restraint policy...will be worn to effectively keep hair from contacting exposed food. Those employees that have hair that extrudes out of the cap will be required to have hair wrapped into a bun style or tucked under hat..."</p> <p>The Policy and Procedure for "Cleaning Stove" provided by the HFA on 04/16/14 at 8:23 A.M. indicated, "Daily: Wipe off stove regularly with clean detergent cloth..."</p> <p>The Policy and Procedure for "Ceilings" provided by the HFA on 04/16/14 at 9:55 A.M. indicated, "...Ceilings are to be inspected quarterly..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>Completion Date 5/15/14</p> <p>Systemic change: dietary team will implement new hair restraint policy to ensure hair is properly contained. Inspect stove burners prior to usage to ensure cleanliness. Visually inspect ceiling in or near food service and preparation area prior to any food preparation or service. DFS or designee will monitor hair restraints, stove burners, and ceiling prior to any food leaving service line or prep, daily.. Plant Operation Dir. to repair cosmetic issues that may occur overhead in the dietary department daily and document accordingly.</p> <p>Completion Date 5/15/14</p> <p>DFS/Designee will audit above measures for compliance as part of ongoing daily sanitation rounds 7 days a week with results forwarded to monthly QA committee meeting for further suggestions and comments.</p> <p>Completion Date 5/15/14</p>	

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were stored in acceptable</p>	F000431	F 431	05/15/2014

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	<p>temperatures and/or were disposed of in a timely manner for 1 of 2 medication rooms toured, 1 of 3 treatment carts reviewed and 1 of 4 medication carts reviewed for medication storage.(Residents #13, #19, #27,#30, #34, #35 and #48)</p> <p>Findings include:</p> <p>1. On 04/16/14 at 9:05 A.M., the 300/400 hall medication room was observed with the Assistant Director of Nursing (ADON). The temperature read 19 F (Fahrenheit degrees), the refrigerator contained 2 open Novo log flex pens (a pre filled multi dose syringe) (Resident #13 and #35), 2 open Lantus flex pens (#35 and #34), 1 unopened Novo log flex pen (Resident #35), 1 open Humalog flex pen (Resident # 34), 1 unopened Humalog flex pen (Resident #34), and 1 open Levamier flex pen (Resident #13).</p> <p>The ADON was interviewed during the observation and indicated the temperature checks were done every night and adjustments to the refrigerator temperature would be made accordingly.</p> <p>Temperature logs for the month of April were reviewed on 4/16/14 at 11:27 A.M., the temperatures were documented out of the acceptable range on 4/10/14 at 26 F, 4/11/14 at 30 F, 4/14/14 at 30 F, 4/15/14 at 18 F, and 4/16/14 at 20 F. The facility range for refrigerator temperatures at the bottom of the page indicated acceptable ranges for the refrigerator temperatures were 35 to 45 F.</p> <p>2. The 200 hall treatment cart was reviewed on 4/16/14 at 9:40 A.M., with LPN #13. The cart contained an open container of Nystat powder dated 11/09/13 (Resident #48).</p>		<p>Resident #13, 35, 34, 48, 19, and 30 expired medications were disposed of per policy. The thermometer in the refrigerator was replaced.</p> <p>Completion Date 5-15-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice therefore through alterations and in-services the campus will assure medications are stored in acceptable temperatures and /or will be disposed of in a timely manner. All refrigerators were audited for proper storage for medications by Director of Nursing. All Medication carts and treatment carts were audited by ADON for proper storage and proper labeling. Audit completed by DON and ADON to ensure all medications were stored properly, audit included inspection for expired medications and proper labeling.</p> <p>Completion Date 5-15-2014</p> <p>Nurses have been in-serviced on campus procedure for monitoring for expired medications, documentation of the dates medication containers were opened, and disposing of unused D/C medications. Campus will request P.C.A. pharmacy to also audit med carts quarterly.</p>	

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	<p>An open tube of Santyl ointment dated 12/20/13, Bactrican ointment dated 6/4/13 and Granulex wound cleansing spray dated 12/9/13 (Resident #19).</p> <p>The cart also contained an open tube of Voltren Gel (a prescription pain relief gel) without a label or open date. LPN #13 indicated during the review the treatments for Residents #19 and #48 had been discontinued and should have been removed from the cart she also indicated that tube of Voltren Gel was used for Resident #30.</p> <p>3. The 200 hall medication cart was reviewed on 4/16/14 at 9:45 A.M., the cart contained pulmacort liquid medication for inhalation, the medication was in an open foil package containing 3 single use vials, no open date was observed on the package. The directions on the label indicated medication in the foil package was good for up to 14 days after opening. The ADON was present during this observation and disposed of the medication indicating an open date should be on the package.</p> <p>During an interview with the ADON on 4/16/14 at 10:40 A.M., she indicated the dates for Resident #19 orders were Bactroban ointment started on 6/4/13 and discontinued on 6/9/14, Granulex spray start on 12/9/13 and discontinued on 12/16/13, and the Santyl was discontinued 12/27/13. She also indicated the Nystat powder for Resident #48 was discontinued on 11/28/13.</p> <p>The policy for the medication storage and labeling was provided by the ADON on 4/16/14 at 9:54 A.M., the policy indicated "...all medications are properly stored and labeled..."</p>		<p>Completion Date 5-15-2014</p> <p>Systemic change: each medication cart/ treatment cart/ medication refrigerator will have a weekly check to assure in compliance with policy.</p> <p>Completion Date 5-15-2014</p> <p>DHS/Designee will review 3 random resident's medication to assure medications dated when opened and checked for expiration 5x a week x one month then 3x a week x one month then weekly thereafter with results to be forwarded to QA committee monthly for review for 6 months and quarterly thereafter to ensure on going compliance and further recommendations/suggestions.</p> <p>Completion Date 5-15-2014</p>	

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F009999	<p>The Director of Nursing (DON) was interviewed on 4/16/14 at 11:45 A.M., she indicated that discontinued medications should be pulled from the carts immediately, logged on the resident ' s medication disposition log and sent back to the pharmacy or destroyed at the facility.</p> <p>3.1-25(m) 3.1-25(o)</p> <p>Administration and Management : 3.1-13 (g) The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks;(B) poisonings;(C) fires; or(D) major accidents.</p> <p>This state rule not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to notify the state agency of flooding in the facility that had resulted in the relocating of residents on the flooded unit to other units of the facility for 1 of 4 units of the facility. (Resident # 92, Resident #5, Resident #46, Resident #13, Resident #82, Resident #23)</p> <p>Findings include:</p> <p>On 4/10/14 at 11:10 A.M.,during interview</p>	F009999	<p>F 9999</p> <p>Resident #92, 5, 46, 13, 82, and 82 suffered no ill effects from the alleged allegation. Completion Date 5-15-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations, processes, and in- servicing the campus will ensure timely notification to the ISDH of unusual occurrences. Completion Date 5-15-2014</p> <p>Systemic change will be the campus will report if a flood would occur in the campus to ISDH immediately per unusual occurrences noted in regulation 410 IAC16.2-51. (g)(1) regardless of service interruption. Campus will take appropriate measure to contact Administrator, D.O.N., and S.S. to aid with reportable and safe practice. Completion Date 5-15-2014</p> <p>ED/Designee will review episodic</p>	05/15/2014

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	<p>with Resident #13, she indicated that she had been moved to the 200 unit last week due to flooding on her unit (400 unit).</p> <p>On 4/14/14 at 11:23 A.M., during interview with the Administrator he indicated that Resident #13 and her roommate, Resident #82 had been moved from the 400 unit to the 200 unit last week due to flooding on their unit. He indicated there had been a large amount of rain on 4/4/14 which had caused flooding in the 400 unit of the facility. The facility had moved 6 residents from the affected rooms to rooms thru out the facility. Residents were moved from rooms 406, 405, 404, and 403, the residents were #92, #5, #46, #13, #82 and #23.</p> <p>The Administrator indicated the facility had hired a company to dry out the water damage. He indicated once the rooms were dried out on 4/9/14, the affected room carpets were then shampooed. He indicated residents were moved back to their rooms on the 400 unit from the dates of 4/9/14 thru 4/11/14. He indicated he had not notified the state agency regarding the flooding of the facility and the transfer of residents to other units in the facility. The Administrator indicated at that time, he had not notified the state agency due to no services had been interrupted.</p> <p>On 4/16/14 at 8:37 A.M., the Administrator indicated he used the state regulations 410 IAC 16.2-51.3 (g)(1) to determine if an unusual occurrence should be reported to the state agency. He indicated he had not reported the flooding of the facility due to it was not an, "(A) epidemic outbreaks; (B) poisonings; (C) fires; or, (D) major accidents..."</p>		<p>events daily to assure reportable guidelines followed. All results of audits will be forwarded to QA for review and further suggestions x 6months.</p> <p>Completion Date 5-15-2014</p>	