

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2013
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NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00134696.</p> <p>Complaint IN00134696 - Unsubstantiated - due to lack of sufficient evidence.</p> <p>Survey dates: September 23, 24, 25, 26, 30, October 1, 2, and 3, 2013</p> <p>Facility number: 000022 Provider number: 155061 AIM number: 100274510</p> <p>Survey team: Gloria J. Reisert, MSW - TC (9/23, 24, 25, 26, 29, 10/2, 10/3/13) Joan Laux, RN Sunny Junglaus, RN Caitlin Lewis, RN Paula Davidson, RN</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 5 Medicaid: 40</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under the state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing the evidence of compliance with the plan of correction. The documentation servers to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Other: 1 Total: 46</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>				

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure all residents in the 200 dining room were served their meal before staff moved onto other tasks during 2 of 2 lunch meal observations. (Residents 7, 16, 29, 33, 60, 62 and 72)</p> <p>Findings included:</p> <p>A.. During the lunch meal observation on 9/24/13 between 12:02 p.m. and 12:25 p.m., the following was observed:</p> <p>1. Resident #16 was eating her meal while Residents #29, 62, 60, 12 and 7 sat at their tables looking at the resident while she ate. Staff then came to take her plate, set up rest of her tray, and then left.</p> <p>In an interview with Residents #60 and 62 during this observation, they indicated "It normally takes a long time to get our meal. Sometimes one may get it and the others sit and wait."</p>	F000241	F241 Requires the facility to ensure all residents in the dining room are served their meal before staff moves onto other tasks.1. Resident 7, 16, 29, 33, 62 and 72 had their meal tray served to them.2. All residents have the potential to be affected. All staff was instructed to serve the meal trays table by table before moving to other tasks during meal service.3. The staff was inserviced on the need to maintain dignity and respect by serving every resident at the dining room table their meal prior to moving to the next table or serving hall trays. 4. The DON or her designee will conduct daily dining room observations to ensure that all residents at the dining rrom table are served their meal prior to moving to the next table or serving hall trays. The DON will ensure that dignity and respect of all individuals are being conducted. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until 100% compliance is obtained and maintained. (See	10/28/2013

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	<p>At 12:17 p.m. on 9/24/13, a CNA [certified nursing assistant] was overheard to yell "We are missing several peoples trays like Residents #29 and 12." LPN #2 was then observed to bring in the trays for Residents #7, 60, and 62 which had been sitting on the cart during this observation.</p> <p>B. During the observation of the lunch meal on second floor on 9/30/13 between 11:55 a.m. and 12:25 p.m., the following observed:</p> <ul style="list-style-type: none"> - At 12:03 p.m., Resident # 60 was in the dining room eating her meal and Resident # 72 was being fed her meal by LPN #2. - Resident #29 was observed to be fidgety and moving his wheelchair back and forth at his table. - Resident #7 was sitting at the same table as Resident #72 and was conversing with the nurse. - Resident #33 was observed sitting at her table with her eyes closed. - Resident #16 was observed seated at her table looking at Residents #60 and #72 while they were eating. <p>At 12:26 p.m., Resident #7 received her meal tray; at 12:18 p.m., Resident #16 received her food tray; at 12:20 p.m., both Residents #33 and #29</p>		attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.		

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	<p>received their meal tray. After receiving his meal tray, Resident #29 was observed to then sit still and eat.</p> <p>During this observation, staff were observed going back and forth from the meal tray cart which contained the trays to deliver hall trays and to the dining room.</p> <p>During an interview with LPN #4 and CNA #1 on 10/2/13 at 10:51 a.m., they indicated that they were taught to serve the room/hall trays first and then serve the dining room trays as that way they could then sit with the residents in the dining room.</p> <p>3.1-3(t)</p>			

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F000253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, record review and interviews, the facility failed to provide a clean and comfortable environment, in that resident bathrooms, shower rooms and hall had peeling paint, rusty pipes, dirty air vents, and/or discolored and chipped areas around the base of the commodes. This affected 9 of 9 rooms observed (201, 202, 204/205 shared bathroom, 208, 209/210 shared bathroom, 214/215 shared bathroom, 2nd floor dining room, 2 of 2 shower rooms on second floor) during 3 of 3 environmental tours.</p> <p>Findings included:</p> <p>A. During the environmental tour on 9/24/13 between 11:55 a.m. and 12:25 p.m., the following was observed:</p> <p>1. Room 201- in the bathroom, the caulking around the base of commode was chipped in areas and had brown/black stains on the floor in front and on the side of the commode; the air vent above commode</p>	F000253	F253 Requires the facility to provide housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. 1. Room 201 had caulking replaced around the base of the commode and stains removed on the floor in front of the commode and on the side of the commode. The air vent above commode was cleaned as well. The ceiling around the light fixture outside of the 2nd floor dining room was fixed and the splotches were removed. Fan in room 208 was dusted, the ceiling tiles were replaced and the bathroom vent was dusted as well. Caulking was replaced around the commode in Room 202. Shared bathroom 204/205 had the chipped and cracked tile repaired at the entrance to the bathroom. Shared bathroom 209/210 had the caulking replaced at the base of the commode. In the bathroom of 209, the brown drip coming from the knob down the wall was cleaned. Vent in the shared bathroom 214/215 was dusted. Wall bathroom and the bathroom door were painted. The scrapes outside the 2nd floor shower room were repaired. Light bulbs were replaced and the caulking	11/01/2013			

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	<p>had a moderate amount of dust coating the inside slats.</p> <p>2. The ceiling around the light fixture outside of the 2nd floor dining room had dark splotches - measuring the length of the short hall.</p> <p>3. Room 208 - her personal fan blades had dust on them and the fan cover; 3 ceiling tiles directly above the inside door of the bathroom had large brown water stains; the bathroom vent had a heavy coating of dust inside the vent.</p> <p>B. During the environmental tour on 9/24/13 between 3:30 p.m. and 4:45 p.m., the following was observed:</p> <p>1. Room 202 - caulking was missing around the commode base with brown stains on the caulking that was left.</p> <p>2. Shared bathroom with Room 204/205: 3 cracked and chipped floor tiles in front of the bathroom entrance.</p> <p>3. Shared bathroom 209/210 - the caulking around base of the block holding the commode was peeling; the inside bathroom door to Room 209 had a brown drip coming from the knob to half way down</p>		<p>was replaced around the commode. Sink knob was replaced with a new faucet. The ceiling was repainted as well. The weight scale was cleaned. The 2nd floor shower room across from 203 had the ceiling painted and rusted pipe was repaired. The stains were removed in the shower stall. Emergency call box was cleaned and painted. Florescent light was covered and light bulbs replaced. The dining room air vents were dusted.2. All rooms of the facility have the potential to be effected. Rounds were conducted to ensure no further issues were needing addressed.3. The maintenance and housekeeping staff was inservice on services that need to be provided to ensure a sanitary, orderly and comfortable environment such as thorough cleaning of stains, lime and items that can accumulate dust. Also the importance of proper lighting and caulking of commodes.4. The administrator or his designee will conduct daily rounds observing for dust, stains, caulking that is cracking or peeling, lime build-up, light bulbs needing replaced and painting that is cracked or chipped. The administrator or his designee will utilize the monitoring tool daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See</p>	

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	<p>door.</p> <p>4. Shared bathroom with Room 214/215: Bathroom vent had a light coating of grey dust inside; the inside bathroom door to 214 had dark scuff marks across the bottom 1 foot section of door; the wall directly across from the commode had a gouged area of missing paint 15 inches in length and 3 inches in height; also a dime size scrape with missing paint in middle of same wall.</p> <p>5. 2nd floor shower room by the Dining Room - outside door to the hall had 3 deep scrapes across the bottom portion of the door measuring 1 foot in length; 1 of 3 bulbs above the sink were burned out; caulking around the base of the commode was chipping away; base of the sink knob had a moderate build up of lime. The ceiling in the shower stall had large chipped paint/plaster areas above the entrance to the stall, around the light fixture and wire protectors on ceiling.</p> <p>6. 2nd floor shower room across from Room 203 - weight scale had a heavy build up of dirt</p>		<p>attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>				

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	<p>along the 3 edges of the base; the ceiling above the shower stall had multiple areas of chipped/peeling plaster; the pipe in the ceiling in this area was rusted at the joint and was directly above the shower chair area where a resident would sit; the left and back wall in the shower stall had brownish-tan stains on the wall tiles extending half way up the walls from the floor; the resident emergency call box in the shower stall was rusted; the florescent light in the shower stall had no cover; and in the bathroom area of the shower room, 2 of 3 lights above the sink were burned out.</p> <p>7. Inside the left and middle air vents in the dining room above the mirror had a heavy build-up of grey dust.</p> <p>During an interview with the Housekeeping Supervisor on 10/2/13 at 1:30 p.m., she indicated that at the end of the day, she will go behind her staff and double check to ensure they have completed their assigned duties each day.</p> <p>C. During an environmental observation with the Maintenance</p>				

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	<p>Director on 10/2/13 at 3:15 p.m., he indicated that he and the Administrator were aware of the peeling/chipping plaster. He also indicated these areas have been present for quite awhile now and that the facility was trying to get approval to re-do the bathrooms with tile instead of the board that was in there now. No costs have been researched yet and no date for repairs had been set.</p> <p>During the observation, the Maintenance Director also indicated that although the bathroom and dining room air vents did have a heavy build-up of dust in them, they were no longer being utilized as the facility had converted to the air conditioning system and no air was coming through the vents. He also indicated that he had replaced some of them but not all yet. He indicated that he was not sure who was responsible for cleaning the air vents - if it was his duty or housekeeping.</p> <p>When shown the commode in Room 201, he indicated that he re-caulked every commode in the building 3 months ago and that staff were supposed to write him a work order whenever they noticed issues which needed to be repaired.</p>			

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	<p>During an interview with the Housekeeping Director on 10/2/13 at 4:00 p.m., she indicated that the housekeeping staff were responsible for the dusting of the outside of the air vents, but was not sure if it was a joint effort or not between her department and the maintenance department in getting the inside of the vents clean.</p> <p>During an interview with the Administrator and Maintenance Director on 10/2/13 at 4:15 p.m., the Administrator indicated that the entire 3rd floor and a few other resident rooms had their air vents replaced some time last year but was unable to exactly say when and which other rooms had the air vents replaced. He indicated the other rooms will eventually have the vents replaced but no set time frame had been developed yet. He also indicated he was aware of the chipped ceiling plaster in the second floor shower room, but was unsure what was going to be done about it as the ceiling was difficult to repair due to the type of material used.</p> <p>On 10/2/13 at 3:33 p.m., the Maintenance Director presented a copy of his Preventative Maintenance logs. Review of the June to</p>			
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	<p>September 2013 logs indicated resident rooms/bathrooms were checked on a weekly basis and the shower rooms were checked monthly for any needed repairs.</p> <p>Review of the Shower room entries during the monthly checks indicated the only repair made for this time frame was to clean a drain. The room check entries indicated painting touch ups were occasionally done along with some night lights and new toilet seat replaced and HVAC filters were cleaned.</p> <p>3.1-19(f)(5)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to complete a comprehensive</p>	F000272	F272 Requires the facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 1. Resident	10/28/2013

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	<p>assessment of the resident's need for a foley catheter. This deficient practice affected 1 of 5 residents with urinary catheters.</p> <p>Findings include: Staff interview with record review on 09/23/13 at 3:00 PM, with LPN (Licensed Practical Nurse) #5 indicated that there was no order for or diagnosis documentation for Resident #52's urinary catheter.</p> <p>Resident #52's record was reviewed on 09/24/13 at 9:15 AM. The record indicated Resident #52 was admitted with diagnoses that included, but were not limited to, Gullian Barre Syndrome, diabetes, high blood pressure, arthritis, history of deep vein thrombosis, dysphagia, depression, chronic pain, diabetic neuropathy, gerd, and atypical psychosis. Admission to the facility was on 08/15/13. The admission orders do not include urinary catheter orders. Resident #52 was admitted with a urinary catheter in place.</p> <p>Interview with LPN #5 on 09/24/13 at 9:35 AM indicated during a chart check that there was no order for Resident #52's urinary catheter, medical necessity, or care for the</p>		<p>#52 had catheter orders and diagnosis for the use of the catheter obtained from the physician. Resident is to be seen by an urologist. 2. All residents have the potential to be affected. Residents with a Foley catheter had their orders reviewed to ensure that catheter care orders were present as well as a diagnosis for the use of the catheter. 3. The catheter care policy and procedure was reviewed with no changes made. The nursing staff was inserviced on the above procedure.(See attachment C)4. The DON or her designee will audit all resident's charts that have a catheter to ensure orders are present for catheter care and a diagnosis to support the use of a catheter. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>		

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	<p>urinary catheter. LPN #5 also indicated that if there was an order that it would be on the monthly physician order form.</p> <p>Interview with DON (Director of Nursing) on 10/02/13 at 1:30 P.M. indicated that the facility does not have a urinary catheter usage policy. The facility goes by the MD order and MDS (Minimum Data Set) guidelines.</p> <p>3.1-31(c)(6)</p>			

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on record review and interview, the facility failed to ensure Qualified Medication Aides [QMAs] performed only tasks within their scope of practice, in that 3 of 3 QMAs administered PRN [as needed] medications without prior nursing approval; assessed residents to determine effectiveness of PRN medications, performed wound/skin assessments, failed to report blood glucose testing results to the nurse and administered insulin injections. This deficient practice affected 3 of 3 residents reviewed for care by a QMA and had the potential to affect 39 of 46 residents currently residing in the facility. (Residents #17, 32 and 55) Findings included:</p> <p>1. Review of the clinical record for Resident #17 on 9/26/13 at 9:13 a.m., indicated the resident was admitted to the facility from the hospital on 7/12/13 and had diagnoses which included, but were not limited to:</p>	F000281	F281 Requires the facility to provide or arrange services that meet professional standards of quality. 1. Resident #17, 32 and 55 had a head to toe assessment completed. 2. All residents have the potential to be affected. Qualified Medication Aides were educated regarding their scope of practice.3. The Qualified Medication Aide job description was reviewed with no changes made. The Qualified Medication Aides were inserviced on the above procedure.(See attachment D)4. The DON or her designee will audit all resident's medication assessment records to ensure Qualified Medication Aides are practicing in their scope but not giving prn medications prior to a nurse assessment and having a nurse document effectiveness. The DON or her designee will also ensure QMA are not administering insulin or conducting skin assessments. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during	10/28/2013

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	<p>seizures, atrial fibrillation, and anxiety.</p> <p>Review of the Admitting Orders from the hospital dated 7/12/13, included but was not limited to: Zofran [nausea medication] 4 mg [milligrams] - 1 tablet PO [by mouth] every 6 hours as needed [PRN] and Tylenol 650 mg every 6 hours PRN. During an interview with the Director of Nursing [DON] on 9/25/13 at 11:30 a.m., she indicated that what orders the hospital sent with the resident, were the ones reviewed with the physician and confirmed.</p> <p>Review of the PRN Medication Flow Sheet for 7/14/13 through 7/25/13 indicated QMA #1 [Qualified Medication Assistant] gave the PRN Zofran on 7/14/13 at 8:30 p.m., without prior nursing approval and subsequently assessed the resident at 9:30 p.m., and determined the medication was effective. Documentation was lacking of the nurse having been present when the QMA determined the medication was effective.</p> <p>On 8/3/13 at 11:30 p.m., QMA #2 gave the resident PRN Tylenol [for pain/fever] 650 mg. Although the QMA did have the nurse's approval to give the PRN medication, the QMA</p>		<p>the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>		

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	<p>subsequently assessed the resident at 12:30 a.m.; and determined the Tylenol was effective. At 12:30 a.m., the QMA then gave the resident the PRN Zofran for complaints of nausea. Although the QMA also had prior nursing approval to give the PRN medication, the QMA then subsequently assessed the resident at 1:30 a.m., and determined the medication was effective. Documentation was lacking of the nurse having been present when the QMA determined the medication was effective.</p> <p>2. Review of the clinical record for Resident #32 on 9/26/13 at 11:17 a.m., indicated the resident was admitted to the facility on 6/4/13 from the hospital and had diagnoses which included, but were not limited to: status post cerebral vascular accident and episodic mood disorder/bipolar disorder.</p> <p>Review of the Controlled Drug Record for June 2013, the resident had an order for Ativan 0.5 mg [milligrams] - tablet every 6 hours as needed [PRN] for anxiety. Per the PRN Medication Flow Record for 6/24 to 6/30/13, QMA #3 gave the resident the PRN Ativan on 6/29/13 at noon, 6/30 at 12:30 p.m., and 6:00 p.m. for complaints of</p>			

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	<p>anxiety. The record indicated that although the QMA had obtained prior nursing approval, the QMA initialed the form that she had assessed the resident an hour later and determined the PRN to be effective. Documentation was lacking of the nurse having been informed of the results or having assessed the resident herself to determine if the medication was effective.</p> <p>3. Review of the clinical record for Resident #55 on 9/26/13 at 10:14 a.m., indicated the resident was admitted to the facility on 4/11/13 from the hospital and had diagnoses which included, but were not limited to: peripheral artery disease, diabetes mellitus and anxiety.</p> <p>Review of the Pressure Ulcer Flowsheet dated 4/25/13, indicated QMA #3 did the assessment of what stage the wound was, a description of the wound/bed and what treatment was being used. A Weekly Skin Assessment form dated 4/25/13 was also completed by the same QMA which indicated "Head to toe skin assessment has been completed. New skin alteration was found. See: Pressure Ulcer Flowsheet."</p> <p>On 6/6/13 at 4:00 p.m., QMA #3 also</p>			

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	<p>completed a Weekly Skin Assessment in which she indicated "Head to toes skin assessment completed. No NEW skin alterations noted (See appropriate skin flowsheet for existing alteration)."</p> <p>On 4/30/13, the resident received an order for Oxycodone HCL 10 milligrams [mg] - 1 tablet by mouth every 6 hours as needed [PRN] for pain.</p> <p>Review of the 5/29 to 6/29/13 Controlled Drug Record indicated QMA #3 gave the resident 1 dose of the Oxycodone at 6:30 p.m. for complaints of pain. Documentation was lacking of the QMA having obtained prior approval by nursing.</p> <p>Review of the PRN medication Flow Sheet for June 2013 indicated that on 6/6/13 at 10:15 p.m., QMA #3 administered 1 dose of PRN Oxycodone without obtaining prior nursing approval. An hour later, the QMA assessed the resident and determined the medication to have been effective.</p> <p>The Admitting Physician Orders dated 4/11/13 indicated the resident had an order for Accuchecks to be performed twice daily at 6:00 a.m. and 4:00 p.m.</p>			
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	<p>Review of the Monthly Blood Glucose Monitoring Record for April, May, and June 2013 indicated QMA #1 and #3 checked the resident's blood sugar and administered routine insulin on the following days:</p> <p>- April:</p> <ul style="list-style-type: none"> - 4/17 - 6:00 a.m. (accucheck only) and 4:00 p.m. - 4/18 - 4:00 p.m. - 4/20 - 4:00 p.m. - 4/21 - 4:00 p.m. - 4/24 - 4:00 p.m. - 4/25 - 4:00 p.m. - 4/26 - 4:00 p.m. <p>- May:</p> <ul style="list-style-type: none"> - 5/1 - 4:00 p.m. - 5/2 - 4:00 p.m. - 5/7 - 4:00 p.m. - 5/8 - 4:00 p.m. - 5/9 - 6:00 a.m. (accucheck only) and 4:00 p.m. - 5/10 - 4:00 p.m. - 5/14 - 4:00 p.m. - 5/15 - 4:00 p.m. - 5/20 - 4:00 p.m. - 5/22 - 6:00 a.m. (accucheck only) and 4:00 p.m. - 5/23 - 4:00 p.m. - 5/27 - 4:00 p.m. - 5/29 - 4:00 p.m. <p>- June:</p>			

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	<p>- 6/1 - 4:00 p.m. - 6/5 - 4:00 p.m. - 6/6 - 4:00 p.m. - 6/12 - 4:00 p.m. - 6/13 - 6:00 a.m. (accucheck only) - 6/15 - 4:00 p.m.</p> <p>Review of the nursing notes between 4/11/13 and 6/30/13 and the Blood Glucose Monitoring Records failed to locate documentation of the nurse having been informed of the resident's blood sugar readings on these dates.</p> <p>On 10/2/13 at 1:15 p.m., the Director of Nursing [DON] presented a copy of a Job Description for the QMA. Review of the Job Description at this time included, but was not limited to: " ...Tasks that the QMA is PROHIBITED from performing: A. Assess a resident's condition ...D. Administer medication by injection ...IV. The QMA Scope of Practice: A. Observe and report to the facility's licensed nurse reactions and side effects to medications exhibited by a resident ...K. Administer previously ordered pro re nata (PRN) medication</p>				

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	<p>only if authorization is obtained from the facility's licensed nurse on duty or on call. If the authorization is obtained, the QMA must perform the following: 1. Document in the resident record symptoms indicating the need for the medication and time the symptom occurred. 2. Document in the resident record that the facility's licensed nurse was contacted, symptoms were described and permission was granted to administer the medication, including the time of contact. 3. Obtain permission to administer the medication each time the symptoms occur in the resident. 4. Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty ...O. Conduct finger stick blood glucose testing (specific to the glucose meter used), reporting result to the licensed nurse ... "</p> <p>Review of the Job Descriptions for the QMAs on 9/30/13 at 2:15 p.m. presented by the Director of Nursing indicated that QMA #1 signed hers on 1/29/08, QMA #2 on 4/27/03 and</p>				

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	QMA #3 on 2/5/04 which indicated they were aware of what a QMA can and cannot do in their scope of practice. 3.1-35(g)(1)			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed administer a seizure medication and an anti-anxiety medication in the correct dosage as prescribed by the physician for 2 of 7 residents reviewed for unnecessary medications. (Residents #17 and 55).</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #17 on 9/26/13 at 9:13 a.m., indicated the resident was admitted to the facility from the hospital on 7/12/13 and had diagnoses which included, but were not limited to: seizures, atrial fibrillation, and anxiety.</p> <p>Review of the Admitting Orders from the hospital dated 7/12/13 included, but was not limited to: Phenobarbital [anti-seizure medication] 32.4 mg [milligrams] by mouth [PO] - 1 tablet daily at noon and Phenobarbital 32.4 mg - give 2 tablets PO daily at night (9 P.M.).</p>	F000282	<p>F282 Requires the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1. Resident #17 and #55 had their physician orders reviewed and medication error sheets completed.2. All residents have the potential to be affected. All resident's orders were verified for accuracy with the October rewrites.3. The physician order policy and procedure was reviewed with no changes made. The nursing staff was inserviced on the above procedure.(See attachment E)4. The DON or her designee will audit all resident's medication assessment records to ensure medications are being distributed per physician orders. The DON or her designee will utilize the nursing monitoring tool to ensure medications are given as ordered daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted</p>	10/28/2013

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	<p>During an interview with the Director of Nursing [DON] on 9/25/13 at 11:30 a.m., she indicated that what orders the hospital sent with the resident, were the ones reviewed with the physician and confirmed as the admitting orders.</p> <p>Review of the 7/13/13 to 8/11/13 Controlled Drug Record indicated the resident was not given the proper dosage of Phenobarbital at the ordered times on the followings days: - 7/17/13 - 9:00 p.m. dose - given 1 pill instead of 2 - 7/19/13 - 9:00 p.m. dose - given 1 pill instead of 2 - 7/20/13 - 9:00 p.m. dose - given 1 pill instead of 2 - 7/21/13 - 9:00 p.m. dose - given 1 pill instead of 2 - 7/25/13 - 9:00 p.m. dose - given 1 pill instead of 2 - 7/26/13 - 9:00 p.m. dose - given 1 pill instead of 2</p> <p>Review of the 7/13 to 7/31/13 Medication Administration Record [MAR] indicated nursing had initialed the boxes for these days as the medication having been administered as ordered by the physician.</p> <p>Review of the nursing notes between 7/13/13 and 7/31/13 did not indicate</p>		accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.	

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	<p>the resident had experienced any seizure activity due to the incorrect amounts of medication being administered.</p> <p>Review of the Initial Care Plans dated 7/12/13 for "The resident has multiple health conditions and is at risk for complications associated with these conditions", listed among the interventions "Monitor for complications and report any findings to the charge nurse for further evaluation and possible physician and responsible party notification; Administer medications as ordered".</p> <p>A Care Plan dated 7/12/13 was also written for "The resident has a diagnosis of seizure disorder and is at risk of injury." Among the interventions listed were "Administer medications as ordered; Phenobarbital as MD [physician] ordered."</p> <p>2. Review of the clinical record for Resident #55 on 9/26/13 at 10:14 a.m., indicated the resident was admitted to the facility on 4/11/13 from the hospital and had diagnoses which included, but were not limited to: peripheral vascular disease, diabetes mellitus, and anxiety.</p>			

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	<p>On 6/26/13, the resident received a new order for Ativan [for anxiety] 0.5 mg [milligrams] - give 1 tablet by mouth [PO] every morning and then give 2 tablets at bedtime.</p> <p>Review of the Controlled Drug Record for 6/28 to 7/21/13, indicated the medication had not been given as ordered by the physician on the following days: - 6/29/13 - 9:00 p.m. dose - only received 1 pill instead of 2 - 7/4/13 - 9:00 a.m. dose - given 2 pills instead of 1 - 7/4/13 - 9:00 p.m. dose - given 1 pill instead of 2 - 7/5/13 - 9:00 p.m. dose - given 1 pill instead of 2 - 7/7/13 - 9:00 a.m. dose - given 2 pills instead of 1 - 7/8/13 - 9:00 p.m. dose - given 1 pill instead of 2</p> <p>Review of the June and July 2013 Medication Administration Records indicated the records were initialed as the medication having been given per physician order.</p> <p>Review of the nursing notes between 6/29/13 and 7/8/13 did not indicate that the resident had experienced an increase in anxiety due to the incorrect amounts of medication</p>				

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	being administered. 3.1-35(g)(2)			

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F000315 SS=D	<p>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 provide medical justification for the resident's need for a foley catheter. This deficient practice affected 1 of 5 residents with urinary catheters. (Resident #52)</p> <p>Findings include: Staff interview with record review on 09/23/13 at 3:00 P.M., with LPN (Licensed Practical Nurse) #5 indicated that there was no order for or diagnosis documentation/medical justification for Resident #52's urinary catheter.</p> <p>Resident #52's record was reviewed on 09/24/13 at 9:15 A.M. The record indicated Resident #52 was admitted to the facility on 08/15/13 with diagnoses that included, but were not</p>	F000315	F315 Requires the facility to 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. 1. Resident #52 had catheter orders and diagnosis for the use of the catheter obtained from the physician. Resident is to be seen by an urologist. 2. All residents have the potential to be affected. Residents with a Foley catheter had their orders reviewed to ensure that catheter care orders were present as well as a diagnosis for the use of the catheter. 3. The catheter care policy and procedure was reviewed with no changes made. The nursing staff was inserviced	10/28/2013

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	<p>limited to, Gullian Barre Syndrome, diabetes, high blood pressure, arthritis, history of deep vein thrombosis, dysphagia, depression, chronic pain, diabetic neuropathy, GERD, and atypical psychosis. The admission orders also do not include any urinary catheter orders. Resident #52 was admitted with a urinary catheter in place.</p> <p>Interview with LPN #5 on 09/24/13 at 9:35 A.M. indicated during a chart check that there was nothing listed for Resident #52's urinary catheter's medical necessity. LPN #5 also indicated that if there was that it would be on the monthly physician order form.</p> <p>Interview with DON (Director of Nursing) on 10/02/13 at 1:30 P.M. indicated that the facility does not have a urinary catheter usage policy. The facility goes by the MD order and MDS (Minimum Data Set) guidelines.</p> <p>3.1-41(a)(2)</p>		<p>on the above procedure. (See attachment C)4. The DON or her designee will audit all resident's charts that have a catheter to ensure orders are present for catheter care and a diagnosis to support the use of a catheter. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>		

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or 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 food was stored under sanitary conditions in dietary in that: meats, fruits, dairy, desserts, and potatoes were found to be open in the refrigerators and freezers in the kitchen without open dates and/or use by dates on them during 2 of 2 kitchen observations. This deficient practice had the potential to affect 43 out of 46 current residents.</p> <p>Findings include:</p> <p>During a dietary tour on 9/23/13 at 11:35 a.m., with the Administrator, in the refrigerator there was a box of bacon, a tub of chicken salad, and a tub of strawberries that had been opened with no "opened date" or "use by" date on them. In the freezer there was sausage, chicken, meatballs, chicken patties, pork riblets, sausage patties, corn, beef nuggets, half a log of bologna, hamburger patties, half of</p>	F000371	F371 Requires the facility to provide or arrange services that meet professional standards of quality. 1. In-servicing completed for dietary staff on 9/25/2013. Topic- proper storage and labeling/dating of food.2. All residents have the potential to be affected. Dietary staff have been in-serviced on proper storage and labeling/dating of food.3. Audit tool will be completed 5 days/wk to ensure food is properly stored and labeled until compliance is acheived. Audit tool will then be completed 4 days/ wk for a month; then 3 days/ wk x 3 wk and 2x/wk for 2 weeks and then weekly thereafter. The audit will be reviewed in the montly Quality Assurance meeting and plan of correction will be adjusted at that time if warrented.4. The above corrective measures will be completed on or before October 28, 2013.	10/28/2013			

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	<p>a ham loaf, premade omelets, 4 cubes of hamburger, and a hamburger log that was open with no "opened on" or "use by" on the packages. In the chest freezer there was chocolate cream pie, toppings for ice cream, frozen cookie dough that had been opened with no "opened on" or "use by" date on the packages.</p> <p>During this dietary tour, the Administrator indicated "I don't know why these things aren't covered; we were dinged on this last year." The administrator then proceeded to remove open undated food items and place them on top of a counter to be thrown away. He indicated "I will have the rest thrown away by the kitchen staff."</p> <p>On 9/25/13 at 10:45 a.m., during an observation of the refrigerator and freezers with the Dietary Manager, a bag of tator tots was observed to be torn open with a 4 inch slit across the top of the bag. When the Dietary Manager took it out of the freezer, it tore again. A large box of beef steaks was also observed open with the steaks exposed to the air. Neither of these items had an "opened on" or "use by" date on them.</p> <p>During the observation on 9/25/13 at</p>				

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	<p>10:45 a.m., the Dietary Manager indicated "Neither of these items have been used. The tator tots are in a weak bag, it must have just got torn."</p> <p>During an interview with the Dietary Manager on 9/25/13 at 2:05 p.m., she indicated "When we get food, we date when it comes off of the truck and any food we open is to have an open date and a use by date on it. Any food that is thawed is put from the freezer to the refrigerator to thaw for 3 days. That is also marked when it is pulled and and when it is supposed to be done thawing. Everyone in the kitchen is supposed to know this. A guess why things weren't marked is I think, ultimately it is my fault, but in their [kitchen staff] minds it was never thawed so that it was just put back in there [the freezer]. I do realize it is suppose to be dated. They [kitchen staff] definitely know in the refrigerator it is supposed to be marked when opened."</p> <p>A review of the New Hire Orientation Checklist for dietary cooks, dietary assistants, and the dietary manager on 9/25/13 at 2:50 p.m., indicated these employees had been orientated on safe food handling, storage of leftover food, food temperatures, and the policy and procedures pertaining</p>			

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	<p>to food service.</p> <p>A policy titled "Storage of Leftovers" was received from the Dietary Manager on 9/25/13 at 2:50 p.m... It indicated "Place leftovers in seamless containers with tight-fitting lids. Label and date all containers with a "Use By" date....Cooked food products should be discarded after three days."</p> <p>3.1-21(i)(3)</p>			
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F000425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents did not receive expired medications as evidenced by 1 resident receiving expired Novolin insulin, 2 residents receiving expired Novolin R insulin, 1 resident receiving expired Novolog insulin, and 1 resident receiving expired Humalog insulin. This deficient practice also had the potential to affect 10 other residents who received insulin. (Resident #3, #37, #42, #47, #52)</p> <p>Findings include:</p>	F000425	F425 Requires the facility to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident. 1. Resident #3, # 37, #42, #47 and #52 had their expired insulin destroyed and pharmacy contacted for reorders of the insulin.2. All residents have the potential to be affected. All resident medications were reviewed to ensure that no expired medications were present.3. The medication expiration policy and procedure was reviewed with no changes	10/28/2013			

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	<p>During an observation of the medication cart on the first floor on 10/2/13 at 10:45 a.m., with RN (Registered Nurse) #1, one opened vial of Novolin insulin belonging to Resident #3 with an open date of 8/28/13. One open vial of Novolin R insulin belonging to Resident #52 had an open date of 8/28/13. One open vial of Novolog insulin belonging to Resident #37 had an open date of 8/28/13. One open vial of Humalog insulin belonging to Resident #42 had an open date of 8/28/13.</p> <p>During an interview with RN #1 10/2/13 at 11:00a.m., she indicated that "insulin should have an open date on them so we know when the expiration is. We do have a sticker that has expired in 28 days; I thought it was 30 days, my mistake."</p> <p>Resident #3 was given expired Novolin insulin per sliding scale on: 9/27/13 at 6:30 a.m. and 4:30 a.m. 9/28/13 at 6:30 a.m. and 4:30 a.m. 9/29/13 at 4:30 p.m. 9/30/13 at 4:30 p.m. 10/1/13 at 4:30 p.m.</p> <p>Resident #37 was given expired Novolog insulin per sliding scale on: 9/27/13 at 6:30 a.m. and 4:30 p.m.</p>		<p>made. The staff was inserviced on the above procedure.(See attachment F)4. The DON or her designee will audit all resident's medications ensuring that if a medication is expired that it is destroyed prior to the medication being given. The DON or her designee will utilize the nursing monitoring tool to ensure medications are not expired daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>		

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	<p>9/28/13 at 4:30 p.m. 9/29/13 at 6:30 a.m. and 6:30 p.m. 9/30/13 at 4:30 p.m. 10/1/13 at 4:30 p.m.</p> <p>Resident #42 was given expired Humalog insulin per sliding scale on: 9/27/13 at 4:30 p.m. 9/28/13 at 6:30 a.m. and 4:30 p.m. 9/29/13 at 6:30 a.m. and 4:30 p.m. 9/30/13 at 6:30 a.m. and 4:30 p.m. 10/1/13 at 6:30 a.m. 10/2/13 at 6:30 a.m.</p> <p>Resident #52 was given expired Novolin R insulin per sliding scale on: 9/29/13 at 4:30 p.m. 10/1/13 at 11:30 a.m. and 11:00 p.m.</p> <p>During an observation of the medication cart on the 2nd floor on 10/2/13 at 11:05 a.m., one vial of Novolin R insulin belonging to Resident #47 was found with an open date of 8/30/13.</p> <p>Resident #47 was given expired Novolin R insulin per sliding scale on: 9/28/13 at 6:30 a.m., 11:30 a.m., and 4:30 a.m. 9/29/13 at 11:30 a.m. and 4:30 a.m. 9/30/13 at 6:30 a.m., 11:30 a.m., and 4:30 p.m. 10/1/13 at 6:30 a.m. and 11:30 a.m. 10/2/13 at 6:30 a.m. and 11:30 a.m.</p>						

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	<p>During an interview with LPN (Licensed Practical Nurse) #4 on 10/2/13 at 11:10 a.m., she indicated that "when insulin is opened, you would write an open date with the date and the nurse 's initials. It can stay open for 28 days, then after that I would document it was expired, white out the resident's name and put the bottle in the sharps container."</p> <p>During an interview with LPN #6 at 11:20 a.m., on the 3rd floor, she indicated that "when opening an insulin vial, you put an opened date on it. It can be open for 28 days after opening. I would throw it away after the 28 days was over."</p> <p>During an interview with the ADON (Assistant Director of Nursing) at 11:35 a.m., she indicated that "with insulin, date it the date it was opened. It can be open for 28 days; usually I slide it into the biohazard waste to discard it after 28 days."</p> <p>A policy titled "Medication Expiration", was provided by the DON (Director of Nursing) on 10/2/13 at 1:23 p.m. The policy indicated: "Multiple dose injectables containing preservatives (including insulin) will expire twenty-eight (28) days of opening."</p>			

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	<p>A policy and procedure titled "Storing Drugs", was provided by the DON at 1:23 p.m... The policy and procedure indicated: "Any outdated, contaminated, or deteriorated drugs...must be removed from stock."</p> <p>A policy and procedure was provided by the DON at 1:23 p.m.The policy and procedure indicated: "Policy: It is the policy of this facility that any medications...will not be administered...beyond its expiration date. Procedure: 1. The nurse will check the expiration date on all medications...prior to administering. 2. Any medication...that has exceeded its expiration date will not be used and should be destroyed."</p> <p>An "Attention Nurses" sheet attached to each med cart on each floor was provided by LPN #6 at 11:35 a.m., which indicated: "Insulins expire 28 days from open date. Make sure all meds have open dates on them."</p> <p>3.1-25(o)</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 insulin and ibuprofen were</p>	F000431	F431 Requires the facility to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing and administering of	10/28/2013			

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	<p>disposed of after the expiration date and also failed to ensure medications were stored at the proper temperatures in the refrigerator on the third floor medication room. This deficient practice had the potential to affect 46 of 46 residents in this facility.</p> <p>Findings include:</p> <p>During an observation of the medication cart on the first floor on 10/2/13 at 10:45 a.m. with RN (Registered Nurse) #1, one opened vial of Novolin insulin belonging to Resident #3 with an open date of 8/28/13. One open vial of Novolin R insulin belonging to Resident #52 had an open date of 8/28/13. One open vial of Novolog insulin belonging to Resident #37 had an open date of 8/28/13. One open vial of Humalog insulin belonging to Resident #42 had an open date of 8/28/13. Resident #25 had expired ibuprofen.</p> <p>During an interview with RN #1 10/2/13 at 11:00a.m., she indicated that "insulin should have an open date on them so we know when the expiration is. We do have a sticker that has expired in 28 days; I thought it was 30 days, my mistake."</p>		<p>all drugs and biologicals to meet the needs of each resident. 1. Resident #3, #25, # 37, #42, and #52 had their expired medications destroyed and pharmacy contacted for reorder of medication. The thermometer was placed in the refrigerator instead of the refrigerator door to get more of an accurate reading.2. All residents have the potential to be affected. All resident medications were reviewed to ensure that no expired medications were present. All thermometers that are kept in the refrigerator was assessed for proper functioning as well as placing them in the refrigerator instead of the refrigerator door.3. The medication expiration policy and procedure was reviewed with no changes made. The staff was inserviced on the above procedure.(See attachment F) The staff was also inserviced on maintaining the correct refrigerator temperature for drug storage.4. The DON or her designee will audit all resident's medications ensuring that if a medication is expired that it is destroyed prior to the medication being given as well as ensuring that the refrigerator temperatures are accurate for medication storage. The DON or her designee will utilize the nursing monitoring tool to ensure medications are not expired and refrigerator temperatures are</p>				

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	<p>During an observation of the medication cart on the 2nd floor on 10/2/13 at 11:05 a.m., one vial of Novolin R insulin belonging to Resident #47 was found with an open date of 8/30/13.</p> <p>During an interview with LPN (Licensed Practical Nurse) #4 on 10/2/13 at 11:10 a.m., she indicated that "when insulin is opened, you would write an open date with the date and the nurse's initials. It can stay open for 28 days, then after that I would document it was expired, white out the resident's name and put the bottle in the sharps container."</p> <p>During an interview with LPN #6 at 11:20 a.m., on the 3rd floor, she indicated that "when opening an insulin vial, you put an opened date on it. It can be open for 28 days after opening. I would throw it away after the 28 days was over."</p> <p>During an interview with the ADON (Assistant Director of Nursing) at 11:35 a.m., she indicated that "with insulin, date it the date it was opened. It can be open for 28 days; usually I slide it into the biohazard waste to discard it after 28 days."</p> <p>A policy titled "Medication Expiration "</p>		<p>accurate for medication storage daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>				

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	<p>was provided by the DON (Director of Nursing) on 10/2/13 at 1:23 p.m. The policy indicated: "Multiple dose injectables containing preservatives (including insulin) will expire twenty-eight (28) days of opening."</p> <p>A policy and procedure titled "Storing Drugs", was provided by the DON at 1:23 p.m... The policy and procedure indicated: "Any outdated, contaminated, or deteriorated drugs...must be removed from stock."</p> <p>A policy and procedure was provided by the DON at 1:23 p.m.The policy and procedure indicated: "Policy: It is the policy of this facility that any medications...will not be administered...beyond its expiration date. Procedure: 1. The nurse will check the expiration date on all medications...prior to administering. 2. Any medication...that has exceeded its expiration date will not be used and should be destroyed."</p> <p>Upon entering the third floor on 10/2/13 at 11:20 a.m., LPN (Licensed Practical Nurse) #6 was observed to be standing next to the medication cart in the main hallway, next to the nurse's station.</p> <p>At 11:25 a.m. the temperature log on</p>			

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	<p>the third floor medication room was dated September, 2013. Temperatures were taken on the 3rd, 10th, and 14th of the month. The August temperature log had been done off and on until August 27th. No temperature was over 40 degrees. This day's temperature according to the thermometer on the inside door of the refrigerator read 50 degrees. The temperature was retaken 3 minutes later. The temperature was 52 degrees at this time.</p> <p>During an interview with the ADON at 11:25 a.m., she indicated that "temperatures are checked daily. That there is a paper to write the temperature on the refrigerator. If the temperature is below 34 degrees or above 40 degrees, then you must address the temperature per a statement written on the bottom of the temperature log sheet."</p> <p>When a recheck of the temperature log was done 5 minutes later for August and September 2013 to obtain copies, they were no longer in the medication room. When the DON presented the temperature logs for these 2 months at 1:23 p.m., it was observed that the temperatures were added that were not previously there when observed during the initial</p>						

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	<p>medication storage inspection.</p> <p>During an interview on 10/2/13 at 1:49 p.m., she indicated that "We do not have a policy on how often the medication refrigerator temperatures need to be taken." She indicated she had asked staff, as she was new, how often they need to be done and no one knew for sure. She gave an example that as she was new and she wanted to make sure things get done. That if a task has to be done weekly, she tells the staff it has to be done daily, if a task has to be done monthly, and she tells them it has to be done weekly so she at least gets something in that week or month that it was needed. She indicated she is continually reminding staff to get these tasks done.</p> <p>During a re-check of the medication refrigerator on the third floor on 10/2/13 at 2:32 p.m., LPN #6 indicated she had just previously been in the refrigerator during the initial identification of the temperature gauge reading of 50 degrees, although she was observed standing at her medication cart at that time.</p> <p>During an interview with the DON at 2:45 p.m., she indicated there was no policy on how often the temperatures</p>						

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	<p>must be taken in the medication refrigerators. She further indicated that she had a daily sheet printed up to place on the refrigerators and hoped that they do it weekly and maintenance did it monthly.</p> <p>During an interview with the Corporate Registered Nurse at 4:07 p.m., she indicated that she had called the facility's pharmacy and obtained the temperature ranges that the medications observed in the refrigerator were to be maintained at. The medication were: Bisacodyl-keep refrigerated to keep its shape Pneumovax-36-46 degrees F Apsol-35.6-46.6 F Captopril-36-46 F Sulfasalazine-36-46 F Spironaldic-36-46 F Bactrim 36-46 F Lansoprazole- 36-46 F Metronialazole 36-46 F</p> <p>3.1-25(m)</p>				

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F000441 SS=D	<p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and</p>	F000441	F441 Requires the facility to establish and maintain an	10/28/2013			

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	<p>record review, the facility failed to follow the facility's policy for handwashing for 4 of 16 observations of handwashing during resident treatments. (Resident's #4 and #31)</p> <p>Findings include:</p> <p>On 09/26/2013 at 3:39:13 PM, Resident #4 was observed to receive coccyx wound care. LPN(Licensed Practical nurse) #5 was observed to wash her hands scrubbing for 10 seconds after having prepared supplies ready before beginning the care for Resident #4 who had just finished showering (there was no old dressing to remove). LPN # 5 put on gloves and cleaned the wound with wound cleaner. LPN # 5 then removed the gloves and washed hands scrubbing for 5 seconds and put on new gloves. LPN #5 then applied skin prep/dated exoderm and put used packaging into the trash. LPN #5 then removed the gloves and washed hands again scrubbing for 5 seconds.</p> <p>On 10/03/2013 at 8:51 A.M., Resident #31 was observed to receive tracheostomy care. RNRT(Registered Nurse Respiratory Therapist) #1 had bedside table clean and supplies ready. RNRT #1 then</p>		<p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Resident #4 and #31 had no noted issues.2. All residents have the potential to be affected. The staff was informed of the need to wash their hands longer.3. The hand washing policy and procedure was reviewed with no changes made. The staff was inserviced on the above procedure.(See attachment G) 4. The DON or her designee will conduct five hand washing observations daily to ensure staff is washing their hands properly and for at least 15 seconds. The DON or her designee will utilize the nursing monitoring tool to ensure hand washing is properly demonstrated daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>		

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	<p>washed her hands scrubbing for 15 seconds. RNRT then prepared her sterile supplies maintaining technique and proceeded to perform the tracheostomy care. After placing used supplies in trash and removing her gloves, she then washed her hands scrubbing for 7 seconds.</p> <p>Interview on 10/03/13 at 2:15 P.M. with LPN #5 indicated that the facility procedure for handwashing was to wet hands, soap, wash for 10 seconds keeping hands down, rinse, paper towel dry hands, then another paper towel to turn off faucet.</p> <p>Interview on 10/03/13 at 2:17 P.M. with CNA (Certified Nursing Assistant) #2 indicated that the facility procedure for handwashing was to wet and soap hands, wash from elbows down/hands low, wash for 2 minutes, rinse, towel pat each arm dry, towel pat each hand dry, towel to turn off faucet.</p> <p>Interview on 10/03/13 at 2:23 P.M. with LPN #6 indicated that the facility procedure for handwashing was before treatments to wash hands and after performing treatments, turn on water faucet, soap, wash, rinse then pat dry, turn off faucet with towel.</p>			

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	<p>Interview on 10/03/13 at 2:25 P.M. with RNRT #1 indicated that the facility procedure for handwashing was to turn water faucet on, soap, wash 15 to 20 seconds, rinse, pat dry, turn off faucet with towel.</p> <p>Review of the Handwashing Procedure provided by the DON (Director of Nursing) on 10/02/13 at 3:00 PM the following: "Rub vigorously for at least 15 seconds" was noted for step #4. 3.1-18(l)</p>			

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F000495 SS=E	<p>483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY</p> <p>A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b).</p> <p>Based on record review and interview, the facility failed to ensure CNA [certified nursing assistant] students completed a State-approved CNA training program in that, student files were missing: documented actual time frames and activities of the classroom and the clinical portion of the course; a submitted application for testing; the actual completed resident care procedures assessment tools; readily accessible PPD [tuberculin] tests and a physical; and documentation of the all assessment tools utilized during the course. This deficient practice affected 7 of 8 CNA students enrolled in the class which ended 9/6/13.</p> <p>Findings included:</p>	F000495	F495 Requires the facility not to use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in State-approved nurse aide training and competency evaluation program; or has been deemed or determined competent as provided. 1. The documented actual time frames and activities of the classroom and clinical portion of the class were placed in the CNA files. A submitted application for testing, assessment tools utilized during the course and actual completed resident care procedures assessment tools were also placed in the files, as well as PPD tests and physicals.2. All future students have the potential to be	10/28/2013	

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	<p>On 10/3/13 between 9:30 a.m. and 11:00 a.m., the Employee files from the CNA class which ended on 9/6/13 were reviewed and the following items were missing from their files:</p> <p>1. CNA Student #1 - documentation of the actual time frames [beginning and end time spent in class every day] and activities of the classroom and the clinical portions of the course [specific activities/tasks worked on every day in class and during clinicals when working with the resident]; documentation of all assessment tools utilized during the course; the actual completed resident care procedures; a copy of the testing information and a copy of the application for testing. A copy of her PPD was also missing.</p> <p>2. CNA Student #2 - documentation of the actual time frames [beginning and end time spent in class every day] and activities of the classroom and the clinical portions of the course [specific activities/tasks worked on every day in class and during clinicals when working with the resident]; documentation of all assessment tools utilized during the course; the actual completed resident care procedures; a copy of the testing information and a copy of the</p>		<p>affected. The Program Director and teacher will ensure that all necessary documents are placed in the CNA file.3. The requirements for CNA training was reviewed with no changes made. The Program Director and teacher was inserviced on the above procedure. 4. The DON or her designee will conduct audits of the CNA student files to ensure all documentation is present in the file. The DON or her designee will utilize the nursing monitoring tool to ensure documentation is present in the file daily times for weeks, then weekly times four weeks then every two weeks times two months then quarterly until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 28, 2013.</p>		

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	<p>application for testing. A copy of her PPD and Physical were also missing.</p> <p>During an interview with the ADON [Assistant Director of Nursing] on 10/3/13 at 10:35 a.m., she stated " I know that we have those PPDs and Physical. No one took the class without them. " No physical was noted in CNA student #2's file. The ADON indicated "Her application is on the DON's [Director of Nursing] desk because she is going to hire on here. I know it is in there."</p> <p>During an interview with the DON at 2:40 p.m. on 10/3/13, she indicated that she had both CNA students files in her office which contained their PPDs and physical because she had been trying to get in touch with them for possible hire.</p> <p>The DON and the ADON also indicated at this time, that they never were taught in their training to become CNA instructors that they had to have the students document every day the times they were in class and when doing their clinicals, nor that they had to document exactly what tasks were worked on or completed every day.</p> <p>3. CNA Student #3 - documentation</p>				

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	<p>of the actual time frames [beginning and end time spent in class every day] and activities of the classroom and the clinical portions of the course [specific activities/tasks worked on every day in class and during clinicals when working with the resident]; documentation of all assessment tools utilized during the course; the actual completed resident care procedures; a copy of the testing information and a copy of the application for testing.</p> <p>4. CNA Student #4 - documentation of the actual time frames [beginning and end time spent in class every day] and activities of the classroom and the clinical portions of the course [specific activities/tasks worked on every day in class and during clinicals when working with the resident]; documentation of all assessment tools utilized during the course; the actual completed resident care procedures; a copy of the testing information and a copy of the application for testing.</p> <p>5. CNA Student #5 - documentation of the actual time frames [beginning and end time spent in class every day] and activities of the classroom and the clinical portions of the course [specific activities/tasks worked on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/03/2013
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
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	<p>every day in class and during clinicals when working with the resident]; of all assessment tools utilized during the course; the actual completed resident care procedures; a copy of the testing information and a copy of the application for testing.</p> <p>6. CNA Student #6 - documentation of the actual time frames [beginning and end time spent in class every day] and activities of the classroom and the clinical portions of the course [specific activities/tasks worked on every day in class and during clinicals when working with the resident]; documentation of all assessment tools utilized during the course; the actual completed resident care procedures; a copy of the testing information and a copy of the application for testing.</p> <p>7. CNA Student #7- documentation of the actual time frames [beginning and end time spent in class every day and activities of the classroom and the clinical portions of the course [specific activities/tasks worked on every day in class and during clinicals when working with the resident]; documentation of all assessment tools utilized during the course; the actual completed resident care procedures; a copy of the testing</p>				

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	<p>information and a copy of the application for testing.</p> <p>During an interview with the ADON on 10/3/2013 10:35 a.m. about the CNA program that she instructed and about the records which were noted to be missing from the CNA student files, the ADON indicated " This is my first class. I may not have everything. I told them that it would be a mess. Someone from a different facility helped me with this class. " When the ADON was asked about the missing applications for the students to take the State test, she indicated " I am still waiting on some students to bring me back their copies of things. They have not tested yet and they are supposed to bring back their information for me to copy and put into their files. " The DON also indicated at this time that " We do require them to bring back their information to copy and put into their files or we do not pay for them to take their test. " The DON also indicated " We should probably put a blank copy into their files while we are waiting for them to bring in</p>			
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	<p>their stuff. "</p> <p>The ADON stated that she had not sent any applications for the students to test because she was still waiting on a few. The ADON also said, "</p> <p>The class is completed, but they had just finished up their hours in August and September. We did go ahead and issue them their certificates of completion of the course. "</p> <p>3.1-14(b)(2)</p>			
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