STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155238	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF YORKTOWN THE	2000 S ANDREWS RD YORKTOWN, IN 47396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 4, 5, 6, 7,10, 2012 Facility number: 000143 Provider number: 155238 Aim number: 100283890 Survey team: Betty Retherford, RN TC Ginger McNamee, RN Karen Lewis, RN Census bed type: SNF/NF: 85 Total: 85 Census payor type: Medicare: 14 Medicaid: 54 Other: 17 Total: 85 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 12/13/12 Cathy Emswiller RN	F0000		

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

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

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F0246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.			
	Based on observation and interview, the facility failed to ensure resident common areas were kept free from storage of equipment so that they could be utilized by the residents for 2 of 2 lounge areas observed. Findings include: During an observation on 12/4/12 at 2 p.m., there were two wheelchairs in the front sitting area which were placed in front of the couch and chair. The residents would have to move the wheelchairs out into the hall area in order to sit in the small sitting area. During an observation on 12/4/12 at 2:05 p.m., there were 4 mechanical lifts stored in the lounge area adjacent to the assist dining room. This room contained a lounge chair, sofa, and love seat. There was a large window in the room which allowed sunshine to come into the room. There was also a bookshelf area which contained multiple books	F0246	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies.The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws. **F246 Reasonable Accommodations of Needs/Preferences** It is the intent of this facility to maintain resident common areas free from medical equipment. 1.**Actions Taken:** All medical equipment removed from the resident's common areas **2. Others Identified:** All residents have the potential to be affected. **3. Measures Taken:** An all -staff in-service, on the need to keep resident common areas free of medical equipment will be conducted on 12-27-12. **4. How Monitored:** a. Dept. Heads will check all common areas during daily walking rounds, to ensure common areas are free of medical equipment. b.	01/09/2013

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	for resident use. The four large mechanical lifts blocked easy access to some of the furniture, bookshelf, or window view. During an observation on 12/5/12 at 2:15 p.m., an unidentified female resident was ambulating with a walker towards the front lounge sitting area. She stopped and looked because multiple wheelchairs were present in front of the furniture. When asked if she would like the wheelchairs moved, she shook her head no and said "it's always a mess up here." She then turned around with her walker and left the lounge area. During an observation on 12/5/12 at 2:15 p.m., there continued to be 4 mechanical lifts stored in the lounge area adjacent to the assist dining room. During an observation on 12/6/12 at 2:00 p.m., there was one wheelchair noted in front of the furniture in the front lounge area and 4 mechanical lifts present in the lounge area adjacent to the assist dining room. During an interview on 12/7/12 at 2:00 p.m., the Administrator indicated the facility should have a better storage area for the wheelchairs and		CEO/designee will review walking rounds sheets daily, on working days, to ensure common areas are free of medical equipment. c. CEO/designee will review a summary of the daily rounds tool, during the monthly QA Meeting with the Medical Director. **5.** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/9/12.	

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	mechanical lifts noted above and they should not be located in resident lounge areas. 3.1-19(w)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review, observation, and interview, the facility failed to ensure a resident with an eye infection was assessed and monitored after the treatment ended to ensure the infection had cleared and failed to assure the resident was monitored and assessed when respiratory problems were noted in order to prevent the development of and/or treat pneumonia for 1 of 1 resident observed with reddened eyes and a cough. (Resident #35) Findings include: 1.) The clinical record for Resident #35 was reviewed on 12/7/12 at 9:05 a.m. Diagnoses for the resident included, but were not limited to, glaucoma, blindness, deafness, depression, and dementia. A quarterly minimum data set assessment, dated 10/3/12, indicated	F0309	**F309 Provide Care/Services for Highest Well Being** It is the intent of the facility to ensure all residents are provided with necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. **1. Actions Taken:** Notified the physician, Erythromycin opthamalic ointment 1/2 inch OU two times 7 days. Received order for chest x-ray and received new order for Cipro 500 mg one by mouth two times a day times 14 days. **2. Others Identified:** 100% audit of those residents experiencing symptoms of infections was conducted to ensure physician notification, treatment and documentation was in place. No other residents were affected. **3. Measures Taken:** An in-service on resident assessment as related to signs/symptoms of infections after ordered ATB is scheduled for 12-27-12.	01/09/2013

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	Resident #35 had severe cognitive impairment and required the assistance of the staff for all activities of daily living. The clinical record indicated the resident was not receiving any eye drops for her glaucoma. The resident had a current physician's order for artificial tears 2 drops into both eyes as needed for dry eyes. The medication administration record lacked any documentation of the eye drops having been given during the month of December 2012. A nursing note entry, dated 11/26/12 at 9:00 a.m., indicated "Noted yellow, crusty drainage on bilateral eyelids with right eye stuck shut with drainage. Eyes washed with warm wash cloth. Denies itching but does confirm some pain and redness. [Name of doctor] notified." The next nursing note entry, dated 11/26/12 at 3:30 p.m., indicated erythromycin ophthalmic ointment (an antibiotic eye ointment) had been ordered to both eyes twice daily for 5 days. Nursing notes, dated 11/28/12 at 2:46 a.m. and 9:00 a.m. and 11/29/12 at 11:00 a.m., continued to note eye drainage from the resident's eyes. The 11/29/12 note above also		**4. How Monitored:** a. The nursing staff will place any resident with a change of condition or symptoms of infection on the 24 hour report sheet. b. The DON/designee will review the 24 hour report sheets on working days. c. The DON/designee will review the medical records of those residents who are experiencing condition changes or symptoms of infection,on working days, to ensure clinical assessments and follow-up is documented. d. CEO/designee will review the findings of the audits at the quarterly QA meeting with the Medical Director. **5.** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/9/12. The facility disputes the scope and severity of F-309 based on documentation to be sent with Plan of Correction providing evidence that there was no harm came to resident #35. The resident was assessed every shift from 11/30/12 through 12/6/12, as evidenced by the 24 hour report sheets. Between the dates of 11/30/12 through 12/6/12 the resident did not require hospitalization, Intravenous fluids for antibiotics nor for hydration. Resident ate well and had adequate hydration as proven by the Food Acceptance record.	

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	indicated the resident had an occasional non-productive cough. The next nursing note, dated 11/30/12 at 1:00 p.m., indicated "Intermittent wet cough still present. Lung fields clear in upper lobes, slightly diminished in bases.... Antibiotic eye gtts continue as ordered. Temperature 97.5." The medication administration record indicated the last dose of erythromycin eye ointment was administered on 12/1/12 at 8:00 p.m. The nursing notes lacked any assessment of the resident's eyes related to the discontinuation of the eye ointment. The nursing notes lacked any assessment of the resident's eye, cough, and/or vital signs from 11/30/12 through 12/6/12 at 1:00 p.m. During an observation of the resident on 12/4/12 at 1:55 p.m., both eyes were noted to be very reddened with crusty drainage on the lower eye lids. During an interview with the resident's roommate (Resident #25) on 12/4/12 at 2:00 p.m., Resident # 35 was noted to have a frequent cough throughout the 15 minute interview.		Resident had no skin breakdown between 11/30/12 through 12/6/12. The physician and the family chose not to treat the glaucoma due to her chronic reds eyes, conjunctivitis, and her age as evidenced by the care plan and physician documentation.	

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	The next nursing note, following the 11/30/12 1:00 p.m. note above, was dated 12/6/12 at 1:00 p.m. The note indicated "Family here, voiced some concern about persistent, non-productive cough. Lung fields clear bilaterally. Also concerned eyes are getting red again. [Name of doctor] office notified." A late entry nursing note, dated 12/6/12 at 2:00 p.m., indicated the resident's vital signs had been taken at 9 a.m. that morning and were blood pressure 112/68, pulse 78, respirations 16, and temperature 98.6. A nursing note, dated 12/6/12 at 6 p.m., indicated a new order had been received for the resident to have erythromycin eye ointment 1/2 inch to be applied to both eyes twice daily for 1 week. An order was also received for the resident to have a chest x-ray. A chest x-ray report, dated 12/6/12 at 6:43 p.m., indicated "modest left lower lobe pneumonia." A nursing note entry, dated 12/6/12 at 7:00 p.m., indicated the x-ray report had been received and the doctor notified. A new order was received for Cipro (an antibiotic) 500 mg tab 1			

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	twice daily for 2 weeks. During an interview with the DoN on 12/6/12 at 1:00 p.m., additional information was requested related to the lack of assessment of the resident's eyes following the last dose of erythromycin ophthalmic ointment on 12/1/12, the lack of any vital signs or monitoring of the resident's cough noted on 11/30/12 thru 12/6/12 when the resident was found to have pneumonia. The facility failed to provide any additional information as of exit on 12/10/12. 3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			
	Based on observation, record review, and interview, the facility failed to ensure residents dependent on the staff for grooming received nail care and were shaved as needed for 3 of 4 residents reviewed of the six who met the criteria for activities of daily living, cleanliness and grooming. (Resident #'s 21, 36, and 61) Findings include: 1.) The clinical record for Resident #21 was reviewed on 12/10/12 at 10:15 a.m. Diagnoses for Resident #21 included, but were not limited to, history of cerebrovascular accident with right hemiplegia, depression, and hypertension. A quarterly minimum data set (MDS) assessment, dated 9/2/12, indicated Resident #21 was severely cognitively impaired and required extensive assistance from the staff for bathing, dressing, and hygiene needs.	F0312	**F312 ADL Care provided for Dependent Residents** It is the intent of this facility to provide ADL care to all residents who are unable to carry out activities of daily living. **1. Actions Taken:** a. Resident #21 fingernails were cleaned and facial hair was removed. b. Resident #61 facial hair was removed. **2. Others Identified:** 100% audit of dependent residents was conducted in regards to long soiled fingernails and facial hair. No other residents were identified. If not , explain how many other residents were found to be affected. **3. Measures Taken:** A nursing in-service on providing and maintaining ADL care to dependent residents is scheduled for 12-27-12. **4. How Monitored:** a. Nurses will monitor facial hair and nail care after showers/bed baths and will sign -off on the bathing sheets. b. DON/designee will review the bathing sheets 5days a week times 2 weeks, then 3 days a week times 3 weeks, then 1 day a week times 6 weeks. c. Dept. Heads will monitor residents' nails and facial hair, on working days, during walking rounds. d. The	01/09/2013

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	A health care problem, last reviewed on 12/3/12, indicated the resident required assistance from the staff for all grooming and hygiene needs. One of the approaches for this problem was for the staff to assist the resident to the sink to perform hygiene and grooming tasks. During an observation on 12/5/12 at 9:00 a.m., Resident #21's fingernails were noted to be long, irregular in shape, with some jagged edges. She also had multiple very long hairs on her chin at least 1/2 inch in length. During an observation with LPN #2 on 12/7/12 at 10:25 a.m., the long fingernails and facial hair were still noted. LPN #2 indicated the resident's fingernails were too long and should be trimmed. 2.) The clinical record for Resident #36 was reviewed on 12/6/12 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, congestive heart failure, and dementia. A quarterly MDS assessment, dated 9/14/12, indicated Resident #36		CEO/ designee will review results of audits at the quarterly QA meeting with the Medical Director. **5.** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/9/12.	

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	required extensive assistance from the staff for bathing, dressing, and hygiene needs. The MDS indicated the resident was unable to speak coherently and was rarely or never understood by others. A health care problem, last reviewed on 11/11/12, indicated the resident required assistance from the staff for all grooming and hygiene needs. Approaches for this problem indicated the staff were to provide showers/bathing per protocol, nail care, oral care, and skin care as needed. During an observation on 12/4/12 at 2:40 p.m., Resident #36 was noted to have facial hair on her chin that was easily noticeable from a short distance. During an observation with LPN #2 on 12/7/12 at 10:20 a.m., the resident's facial hair was still noted. LPN #2 indicated the resident's did have noticeable facial hair on her chin. 3.) The clinical record for Resident #61 was reviewed on 12/10/12 at 10:20 a.m. Diagnoses for Resident #61 included, but were not limited to, acute debility,			

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	depression, dementia, and anemia. A quarterly MDS assessment, dated 11/10/12, indicated Resident #61 was severely cognitively impaired and required extensive assistance from the staff for bathing, dressing, and hygiene needs. A health care problem, last reviewed on 11/7/12, indicated the resident required assistance from the staff for all activities of daily living. One of the approaches for this problem was for "one person to assist with bathing." During an observation on 12/5/12 at 9:40 a.m., Resident #61's fingernails were noted to be long and jagged with lots of fingernail polish flaking off. During an observation with LPN #2 on 12/7/12 at 10:20 a.m., the resident's fingernails continued to be long and some were jagged. LPN #2 indicated the resident's fingernails were too long and should be trimmed. The current 1/07, "Partial Bath (AM and PM)" policy was provided by the Administrator on 12/10/12 at 9:15 a.m., and indicated the following: "POLICY: To observe, cleanse and refresh the resident at the beginning and end of the day. RESPONSIBILITY: All Nursing staff.			

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	EQUIPMENT: ...7. Nail clippers, orange stick, and nail file as needed 8. Razor, shaving cream, basin of warm water....PROCEDURE: ...17. Provide nail care if needed. 18. Provide/assist with removal of facial hair if needed...." 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			

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F0371 SS=E	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			
	Based on observation, interview, and record review, the facility failed to ensure ice and frozen chicken were stored in a sanitary manner during 2 of 3 observations of the walk-in freezer in the kitchen. This had the potential to effect 82 of 85 residents who received iced beverages during meals and/or activities. Findings include: During the initial kitchen tour, conducted with the Administrator on 12/4/12 at 9 a.m., the following was noted: Multiple (at least 7) 10 pound bags of ice were stored directly on the floor of the walk-in freezer beneath the bottom freezer shelf. Boxes of frozen noodles and diced ham were stored on the shelf above the ice. A box of frozen raw chicken tenders was sitting on the floor of the freezer. The box was open and was approximately one third full.	F0371	**F371 Food Procure, Store, Prepare/Serve Sanitary** It is the intent of this facility to ensure ice and frozen chicken are stored in a sanitary manner inside the walk-in freezer. **1.Actions Taken:** Bags of ice and frozen chicken were immediately discarded on 12-4-12. **2. Others Identified:** All residents are potentially affected. **3. Measures Taken:** The dietary staff are to be in-serviced on proper storage of food in the dietary kitchen on 12-27-12. **4. How Monitored:** a. The Dietary Manager/or designee will monitor the freezers and walk-ins on a daily basis to ensure all foods are stored in a sanitary manner. b. The CEO/ designee will monitor weekly times two weeks then monthly thereafter. c. The CEO/designee will review results of audits at the quarterly QA meeting with the Medical Director. **5.** This plan constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/9/12.	01/09/2013

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NAME OF PROVIDER OR SUPPLIER WATERS OF YORKTOWN THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S ANDREWS RD YORKTOWN, IN 47396	

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	During an interview with the Administrator at that time, he indicated the facility had recently had a "boil water" order and the ice had been purchased so the facility could provide cold drinks. He indicated the "boil water" order had now been lifted. During an observation with the Administrator on 12/4/12 at 10:30 a.m., the box of frozen chicken and bags of frozen ice remained on the floor of the freezer. He indicated the items should not be on the floor. He indicated there was no where else they could have stored the ice and he would have all the ice removed and discarded at this time. He gave the box of frozen chicken which had been sitting on the floor to the staff for disposal. The current 2007, "Stock Storage" policy was provided by the Administrator on 12/10/12 at 9:15 a.m. The policy indicated the following: "Food shall be stored on shelves in areas which provide the best preservation and be stored at a proper temperature for appropriate lengths of time. PURPOSE: To protect quality of food and to control costs. PROCEDURE: ...3. Shelves in all areas shall be kept at least two inches from walls to allow ventilation,			

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	six inches off the floor to allow for proper sanitation and 18 inches from the ceiling for fire safety.... e. Frozen meats, poultry and other frozen items will be stored on the lowest possible shelves in the designated refrigerator location...." 3.1-21(i)(3)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to	F0441	**F441 Infection Control, Prevent Spread, Linens** It is the intent of	01/09/2013

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	ensure handwashing and the cleaning of glucose meters were performed as indicated for 1 of 2 observations of blood sugar monitoring. [RN #1, Resident #115] This had the potential to effect 17 of 17 residents residing in the building with orders for blood sugar monitoring. Findings include: An observation of RN #1 testing Resident #115's blood sugar was made on 12/5/12 at 11:00 a.m. The RN donned gloves and performed the finger stick on Resident #115. The RN indicated the blood glucose meter did not register the results and he needed to redo it. The RN removed his gloves, disposed of them, exited the room, and went to the medication cart stationed in the hall outside of the resident's room. He obtained a different blood glucose meter and returned to Resident #115's room. He donned gloves and performed the blood sugar test again. The resident's blood sugar level indicated the resident would require insulin. RN #1 removed his gloves, disposed of them and returned to the medication cart. He retrieved the resident's insulin flex pen from the medication cart and dialed it to the correct dose. He donned gloves and administered		the facility to ensure proper handwashing is followed and to ensure infection control precautions are utilized when cleaning glucometers. **1. Actions Taken:** a. Staff working during survey on 12-5-12 were immediately in-serviced on handwashing. b. Nurses working during during the survey were in-serviced on 12-5-12 on cleaning of glucometers. **2. Others Identified:** All residents have the potential for being affected. **3. Measures Taken:** a. An in-service on proper handwashing and cleaning of the glucometers is scheduled for 12-27-12 **4. How Monitored:** a. DON/designee will observe glucometer cleaning and competencies daily for two weeks, then weekly for one month, then monthly on-going. b. DON/designee will sign off on diabetic supplies after Medical Records has checked and initialed that supplies are not expired upon arrival. c.Nurses will initial they have checked expiration dates on diabetic supplies before they place items, in back-up, on med carts. d.DON/ designee will perform random handwashing competency check-offs, on-going. e. CEO/designee will review the results of audits at quarterly QA meetings with the Medical Director, to determine if further action is needed. **5.** This plan of correction constitutes our credible	

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	the insulin to the resident. He removed his gloves and disposed of them. Upon returning to the medication cart both blood glucose meters were placed on top of the cart. The RN replaced the insulin flex pen in the medication cart and indicated he had to perform a blood sugar test on another resident. No hand hygiene had been performed throughout the observation and the blood glucose meters had not been cleaned.. RN #1 indicated he needed to perform a blood sugar test on another resident. He picked up one of the blood glucose meters from the top of the medication cart and started down the hall to another resident's room. The RN indicated the blood glucose meter is suppose to be cleaned with a chlorine wipe after use and he had not cleaned it. He returned to the medication cart to look for a chlorine wipe to clean the meter. He indicated he had no chlorine wipes on the cart. He opened an alcohol swab and wiped off the face of each meter. He again started down the hall to perform a blood sugar test on another resident. The Director of Nursing indicated the meter must be cleaned before it is used on another resident and provided chlorine wipes to the		allegation of compliance with all regulatory requirements. Our date of compliance is 1/9/12.	

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	RN. She indicated alcohol swabs were not appropriate to use to clean the meters with. The RN used a chlorine wipe to clean each meter. When he finished wiping off the second meter, he immediately took a tissue and dried the first meter. He indicated the solution was to be left on the meters for a couple of minutes. The empty packet for the "Gluco-Chlor" disinfectant wipes used to clean the glucose meters was provided by RN #1 on 12/5/12 at 11:23 a.m. The instructions indicated a five minute contact was required for effectiveness and was to be air dried. During further review of the packet it was noted the expiration date was 05/12. The Director of Nursing was informed of the outdated wipes at 11:28 a.m. on 12/5/12. She indicated the wipes all came in from the same shipment and the shipment was recent. She indicated the facility had four medication carts and each cart had two blood glucose meters on them. She indicated the disinfectant wipes on all the carts were from the same shipment with the same expiration dates.			

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	During a 12/5/12, 11:33 a.m., interview with the Medical Record staff member , she indicated there were six boxes of wipes in the supply room and they all had the expiration date of 05/12. She indicated these were the only disinfectant wipes in the facility for cleaning the glucose meter. She indicated she puts stock away when it comes in and she does not check the expiration dates on the stock. She indicated she could not remember when they were received. The 7/11, current "Handwashing" policy was provided by the Administrator on 12/10/12 at 9:15 a.m. The policy indicated the facility was to use proper handwashing technique to prevent the spread of infection as per the "Center of Disease Control [CDC] Guidelines (Guideline for Infection Control in Hospital Personnel.)" The Director of Nursing provided the 7/1/11, "Hand Hygiene Guidelines Fact Sheet" on 12/10/12 at 2:57 p.m. She indicated the fact sheet was from the CDC and was part of the facility's handwashing policy. The fact sheet indicated "Improved adherence to hand hygiene (i.e. hand washing or use of alcohol based hand rubs) has			

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	been shown to terminated outbreaks in health care facilities....The use of gloves does not eliminate the need for hand hygiene....Handrubs should be used before and after each patient just as gloves should be changed before and after each patient...." During an interview with LPN #2 on 12/10/12 at 2:50 p.m., she indicated hands should be washed before and after resident care and anytime gloves are removed. 3.1-18(l)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 1 of 3 residents reviewed for accidents. (Resident #77) Findings include: The clinical record for Resident #77 was reviewed on 12/7/12 at 10:17 a.m. Diagnoses for Resident #77 included, but were not limited to, Parkinson's disease, depression, diabetes, and hypertension. A nursing note, dated 11/30/12 at 2:15 a.m., indicated the resident was in bed with eyes open. The note also	F0514	**F514 Resident Records-Complete/Accurate/Accessible** It is the intent of the facility to maintain and ensure clinical records are complete and accurate in regards to transfers to and from hospitals. **1.Actions Taken:** Medical records that pertained to transfers to and from the hospital were audited for completeness. No other medical record was affected and medical documentation complete. **2.Others Identified:** Residents transferred to and from hospitals have the potential of being affected. **3.Measures Taken:** A nursing in-service on proper documentation of resident transfers to and from hospitals, is scheduled for 12-27-12. 4.**How Monitored:**	01/09/2013

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	indicated resident had no complaints of pain or discomfort and no signs or symptoms of distress. The next entry was dated 11/30/12 at 3:00 p.m., and indicated the resident had returned to facility from the hospital. The nursing notes for Resident #77 lacked any information related to why the resident had been sent out of the facility. During an interview with the Assistant Director of Nursing on 12/7/12 at 1:37 p.m., she indicated Resident #77 had been sent to the emergency room due to a problem with his feeding tube. She also indicated the reason for the resident's transfer to the emergency room was on the transfer paperwork but not in the nurses notes. Review of the current facility policy, dated 4/06, titled "MEDICAL RECORDS," provided by the Administrator on 12/10/12, at 9:15 a.m., included, but was not limited to, the following: "POLICY:... ...PROCEDURE: 1. Each resident will have an active medical record. This resident record		a. DON/designee will monitor transfer sheets and review 24 hour report sheets, for resident transfers to and from hospitals, on working days. This monitoring will be on-going. b. DON/designee will review the clinical records of those residents who have had transfers, to ensure documentation is in place and complete. This monitoring will be on-going. c. CEO/designee will review audits at the quarterly QA meeting with the Medical Director. **5.** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/9/12.	

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	shall be kept current, complete, legible and available at all times to authorized personnel.... ...2. a. Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded...." 3.1-50(a)(1) 3.1-50(a)(2)			