

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2013
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NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: June 3, 4, 5, 6, 7, and 10, 2013</p> <p>Facility number: 012466 Provider number: 155786 AIM number: 201014060</p> <p>Survey team: Janet Stanton, RN--Team Coordinator Michelle Hosteter, RN Gloria Bond, RN</p> <p>Census bed type: SNF--27 SNF/NF--119 Total--146</p> <p>Census payor type: Medicare--27 Medicaid--102 Other--17 Total--146</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on June 14, 2013.</p>	F000000	F 0000Please find the attached plan of correction for the recertification and state licensure survey. Performed on June 3-June 10, 2013. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a post survey revisit.	

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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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to honor the choice of method of bathing, for 1 of 1 residents who preferred a tub bath and was reviewed for bathing preferences. (Resident #57)</p> <p>The findings include:</p> <p>1. In an interview on 6/5/13 at 12:08 P.M., a family member for Resident #57 indicated the resident used to bathe every day in the bath tub, but now gets a shower.</p> <p>In an interview on 6/5/13 at 1:00 P.M., the DON (Director of Nursing) indicated the facility does have a bath tub available to the residents.</p> <p>The record for Resident #57 was reviewed on 6/6/2013 at 1:45 P.M. Diagnosis included, but was not limited to, senile dementia, hypothyroidism, diabetes, history of</p>	F000242	<p>F242</p> <p>1. What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <ul style="list-style-type: none"> · Resident "A" was offered and given tub bath per choice. <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected. · Residents will be given the choice of shower or tub bath for every bath <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · Licensed nursing staff was in-serviced by Staff Development Coordinator on June 19th, 2013, and June 20 th , 2013 regarding resident right to make choice on tub bath or shower. · DNS/Designee will monitor residents' choice of tub bath or 	07/10/2013	

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	<p>bowel obstruction with a colostomy.</p> <p>The annual MDS (Minimum Data Set) assessment, dated 12/11/2012, indicated it was very important to the resident to be able to choose between a tub bath, shower, bed bath, or sponge bath.</p> <p>Resident #57's care sheet indicated she was getting a shower.</p> <p>On 6/7/2013 at 9 A.M., with the Activities Director in attendance, the facility's bath tub was observed. The the seat over the bath tub, and the bottom of the bath tub was observed to be covered with dust and lint rolls. After the Activities Director touched the gray particles, he confirmed the the bath tub was soiled.</p> <p>3.1-3(u)(1)</p>		<p>shower with CQI tool to ensure all licensed Nursing staff give resident choice of tub bath or shower.</p> <ul style="list-style-type: none"> · Residents will be given the choice of shower or tub bath for every bath · DNS/ Designee will monitor bath tub frequently to ensure cleanliness · Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination. <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · To ensure compliance the DNS/Designee is responsible for Tub bath CQI weekly X4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. · If threshold of 100% is not achieved, an action plan will be developed to assure compliance. <p>5. Date of compliance July 10th, 2013.</p>		

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide outdoor activities for 2 of 3 residents reviewed for outdoor activities in a sample of 3. (Resident # 76, and #207)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #76 was reviewed on 6/3/13 at 3 P.M. Diagnoses included, but were not limited to, diabetes, depression, and high blood pressure.</p> <p>On the MDS (Minimum Data Set) assessment, dated 10/9/12, the resident indicated it was "somewhat important" to him to be able to go outside to get fresh air when the weather is good, and was "somewhat important" to do his favorite activities.</p> <p>In an interview with resident #76 on 6/4/13 at 10 A.M., he indicated he is unable to go outside on his own without staff, and that he would like to</p>	F000248	<p>F248</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · Resident "76" and "207" were allowed to utilize the courtyard at their will. <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected · Activity Director will interview all the residents regarding their activity preference. · Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding resident activity needs. <p>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur.</p> <ul style="list-style-type: none"> · Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding resident activity needs. 	07/10/2013	

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	<p>get outside more often.</p> <p>The documentation of each resident's individual participation in activities were marked on separate activity calendars by the AD (Activity Director). The March, April and May, 2013 activity calendars for Resident #76 were provided by the AD (Activity Director) on 6/7/13 at 2:20 P.M.</p> <p>The calendar for March indicated the resident participated in some of the activities. None of the activities offered were outdoor activities.</p> <p>The April calendar indicated the resident participated in some of the activities. None of the activities offered were outdoor activities.</p> <p>The care plan for activities dated 2/14/13 indicated, "... will participate in independent activities to his level of satisfaction and will be open to alternative programming." Interventions included: "encourage daily socialization outside of room, encourage participation in scheduled programming, enlist family support, offer items for room, [books puzzles, magazines] and re-evaluate for changes in mood/well being."</p>		<ul style="list-style-type: none"> · Activity Director has added outdoor activity to activity calendar. · Any staff not adhering to policy will receive education, disciplinary action up to and including termination <p>4. How the corrective action will be monitor to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · To ensure compliance the Activity Director/Designee is responsible for activity CQI weekly X4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. · If threshold of 100% is not achieved, an action plan will be developed to assure compliance. <p>5. Date of compliance July 10th, 2013.</p>		

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	<p>2. The record for Resident #207 was reviewed on 6/7/13 at 2 P.M. Diagnoses included, but were not limited to, dementia and high blood pressure.</p> <p>In an interview on 6/4/13 at 2 P.M., the resident indicated he would like to be able to go outside more often.</p> <p>The annual MDS (minimum data set) assessment dated 2/7/13, indicated resident was moderately cognitively impaired, and it was his preference and very important to go outside to get fresh air when the weather was good.</p> <p>The care plan dated 3/21/13 indicated , "... will participate in independent activities to his level of satisfaction and will be open to alternative programming." The interventions were to "encourage daily socialization outside of room, encourage participation in scheduled programming, enlist family support, offer items for room, [books puzzles, magazines] and re-evaluate for changes in mood/well being. Resident will be given verbal reminders as to time and place of activities, and will be assisted to and from facility programming as needed...."</p>			

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	<p>The documentation of each resident's individual participation in activities were marked on separate activity calendars by the AD (Activity Director).</p> <p>The individual activity calendars for March, April, and May indicated Resident #207 did not go on the resident outing (a trip in the facility bus), but had not declined to go. None of the activities offered were for outdoor activities.</p> <p>3. On 6/5/13 and 6/6/13 residents residing in the main portion of the building were observed doing all of the activities inside in the activity room. There were no residents observed in the court yard or outside in the front of building. The court yard was all cement with no plants or grass and had two tables with 2 chairs. There were residents that were taken outside by family members, but no observations of staff taking residents outside. The temperature outside both days was in the mid 70's and no rain.</p> <p>The June activity calendar was provided by the Activity Director on 6/6/13 at 1:45 P.M. There were two activities titled "Resident Outing".</p>			
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	<p>During an interview on 6/7/13 at 9:20 A.M., the Activity Director indicated they try often to get residents outside, as well as go out with residents in the courtyard and do 1:1 with residents. He indicated the resident outings included going out to various places in the community on the bus. He indicated residents are able to go out without staff supervision. He indicated they track activities, including outdoor activities on a calendar. The color green indicated refusal, red indicated active in activity, yellow indicated passive, purple indicated LOA (leave of absence) or hospital. He also provided a list of residents that they track who refused the resident outings.</p> <p>3.1-33(a)(2)</p>				

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F000309 SS=D	<p>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.</p> <p>Based on record review and interview, the facility failed to identify and treat pain issues for 1 resident who had sustained a fractured hip with a surgical repair, for 1 of 5 residents reviewed for pain. (Resident #114)</p> <p>Findings include:</p> <p>Record review for Resident #114 was completed on 6/6/13 at 9 A.M. The resident was admitted to the facility on 4/1/13 after surgery in an acute care hospital to repair a fractured hip, which he sustained in a fall at home. Admission diagnoses included, but were not limited to, senile dementia-Alzheimer's type, coronary artery disease, high blood pressure, and a history of frequent falls.</p> <p>On admission, the physician ordered scheduled pain medications of Tramadol 50 mg. (milligrams) 1 tablet by mouth every 12 hours, and</p>	F000309	<p>F 309</p> <p>1. What corrective action(S) will be accomplished for those residents found to have been affected by deficient practices.</p> <ul style="list-style-type: none"> · Residents "D" no longer reside in the facility. <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected · All residents had new pain assessment completed. · Licensed staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding pain management. <p>3. What measure will be put into place or what systemic changes will be made to ensure that deficient practice does not recur.</p> <ul style="list-style-type: none"> · Licensed staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding pain management. 	07/10/2013	

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	<p>Oxycodone 10 mg. by mouth twice a day. The admission orders included PRN (as needed) pain medication of Oxycodone 10 mg. every 4 hours as needed for pain, and Acetaminophen 325 mg. 2 tablets every 4 hours as needed for pain.</p> <p>The facility's initial pain assessment tool dated 4/1/13 indicated the resident was having severe pain almost constantly.</p> <p>The admission MDS (Minimum Data Set) assessment dated 4/8/13, indicated the resident was severely cognitively impaired.</p> <p>The nursing assessments for the first 72 hours as well as a weekly nursing assessment indicated the resident was complaining of pain. The initial assessment done for the resident upon admission indicated the resident stated he had severe pain almost constantly, with movement causing the pain to increase.</p> <p>The admission temporary care plan, dated 4/1/13, indicated, "... resident had pain related to R [right] hip Fx [fracture] with repair." The goal was for the resident to have no pain, with relief of pain within 30-60 minutes of intervention. The Interventions were</p>		<ul style="list-style-type: none"> · DNS/Designee utilized pain CQI tool to determine resident level of pain and intervention · DNS/Designee will monitor all residents with pain issue daily in morning meeting to ensure pain is well control. · Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination <p>4. How the corrective action will be monitor to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place</p> <ul style="list-style-type: none"> · To ensure compliance the DNS/Designee is responsible for pain CQI tool weekly X 4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. · If threshold of 100% is not achieved, an action plan will be developed to assure compliance. <p>5. Date of compliance July 10th, 2013</p>				

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	<p>listed as "medications as ordered, non medication interventions such as rest, quiet environment, therapies as ordered, evaluate effectiveness of interventions and notify MD [physician] as needed..."</p> <p>A physician's progress note dated 4/2/13 indicated, "...CNA reported pt [patient] gets agitated/hits /yells at staff with movement. Patient complains of pain in right hip with movement..."</p> <p>Progress notes for Resident #114 indicated the following: "4/2/13, 2:23 P.M., ...resident complains of right back pain...pain meds [medications] administered as scheduled... 4/4/13, 2:56 P.M., ...resident combative with care... 4/5/13, 2:06 P.M., combative behavior when providing care at times... 4/8/13, 2:31 P.M., resident would yell out when being provided care and grit his teeth... 4/9/13, 7:30 A.M., CNA's providing am care with much difficulty this am. Is combative with care and constantly pushes against staff while trying to bathe... 4/10/13, 2:07 P.M., res became combative with CNA [Certified Nursing Aid] and this nurse while</p>						

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	<p>providing care... 4/11/13, 11:35 A.M., IDT [Interdisciplinary Team] notes indicated will attempt to get a small abduction pillow for res [resident] to alleviate pain...Therapy is working with res for his discomfort and ailments associated with his partial hip replacement. We will also speak with doctor about increasing res pain medications for more comfort. Res also put on trial dose of Ativan for anxiety...</p> <p>4/12/13, 2:01 P.M., combative towards nurse when assisting to reposition...</p> <p>4/14/13, 2:16 P.M., resident alert to self and very confused. Unable to verbalize needs. Increased anxiety noted, res would state he was in pain, ask for pain med and when coaxed and attempting to administer pain meds res would swing at nurse. Resident knocked pain meds out of nurses hand. Resident attempted to hit nurse numerous times, res prompted on behavior resident would state he was in pain, ask for pain med after administer, and then state he was not in pain when holding nurses hand. if resident was not holding nurses hand he would aggressively ask for pain meds and state he was in pain...</p> <p>4/16/13, 2:57 P.M., res sent out via</p>						

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	<p>911 to [hospital name] res displayed increased pain...."</p> <p>The resident went to the hospital on 4/16/13. Upon his return to the facility, the hospital discharge instructions indicated a diagnosis of arthralgia (pain), and he was given orders for the pain medication Hydrocodone.</p> <p>The Medication Administration Record for the resident indicated he received his scheduled pain medication as ordered from admission through 4/16/13.</p> <p>The documentation on the Medication Administration Record indicated he received an additional PRN medication of Tylenol 325 mg. 2 tablets only once, on 4/15/13.</p> <p>The care plan dated 4/18/13 indicated "...administer meds as ordered. Non medication interventions such as rest and quiet environment. Therapies as ordered. Notify MD if pain is unrelieved and/or worsening...."</p> <p>In an interview 6/7/13 at 3:10 P.M., R.N. #2 indicated Resident #114's non-verbal pain indicators were gritting his teeth and wincing. She indicated he was a very anxious, and</p>				

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	<p>it was hard at times to differentiate which was pain and which was anxiety. The nurse indicated the resident seemed to have his pain controlled by the standing dose of pain medications, and that was why they never gave the PRN pain medications. She indicated she knew he was a post hip fracture, and staff had followed the orders as to what was in place regarding the hip fracture. She indicated the resident's confusion made it harder to judge his pain level, as he would indicate that he was in pain and then state he was not in pain. The nurse indicated if there was an increase in pain from their assessment, they would create an "Event" entry in the "Hot Charting" regarding increase in pain, and then chart and offer medication accordingly.</p> <p>In an interview with the Assistant Director of Nursing on 6/10/13 at 1:45 P.M., she indicated she would see non-verbal signs of pain in residents with dementia as fidgeting and resistive to care.</p> <p>The pain policy provided by the Director Of Nursing on 6/7/13 at 2:15 P.M., indicated, "...Non interviewable resident-The pain management program will be determined based</p>				

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	<p>upon staff observation of non-verbal signs of pain as follows:...facial expressions...clenched teeth...protective body movements or postures...."</p> <p>3.1-37(a)</p>			

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F000371 SS=D	<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 Based on observation and interview, the facility failed to ensure dietary staff practiced effective handwashing and sanitization procedures while preparing and serving food for 1 of 2 kitchen observations. This deficit practice had the potential to affect 146 of 146 residents who received food from 1 of 1 kitchens.</p> <p>Findings include:</p> <p>On 6/3/13 at 11:00 A.M., Dietary Aid # 6 was observed to touch the refrigerator door handle and then put gloves on to work with the "shortbread" she was preparing for residents. She did not wash her hand prior to donning the gloves. She also dipped her knife for cutting the bread in a sanitizing solution bucket.</p> <p>On 6/3/13 at at 11:10 A.M., Dietary Cook #4 was observed going from the refrigerator to other food preparation areas, touching door handles and</p>	F000371	<p>F 371</p> <p>1. What corrective action(S) will be accomplished for those residents found to have been affected by deficient practices.</p> <ul style="list-style-type: none"> · Staff " #4, #5 and #6" were in serviced on hand washing <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected · Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding hand washing. · Dietary manager in serviced dietary staff on hand washing, proper placement of scoop, handling of equipment, gloving on 6/11/2013 <p>3.What measure will be put into place or what systemic changes will be made to ensure that deficient practice does not recur.</p> <ul style="list-style-type: none"> · Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding hand washing. · Hand hygiene audit was 	07/10/2013	

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	<p>drawers. She then put on disposable gloves and started to work with the food, but did not was her hands prior to donning the gloves.</p> <p>On 6/3/13 at 11:27 A.M., Dietary Aid #5 was observed to wheel her prepared cart from the kitchen to the Cottage unit. She touched door knobs and other items before she placed gloves on to serve food to the residents in the Cottage unit. She did not wash her hands before donning the gloves.</p> <p>On 6/3/13 at 11:45 A.M., in the Cottage unit, Dietary Aid # 5 was observed placing a scoop for the soup on top of the steam table where surface was visibly soiled. She then used the scoop to serve the soup to the residents.</p> <p>In an interview on 6/10/13 at 1:45 P.M., the Dietary Supervisor indicated she expected staff to wash their hands before touching food, after touching other objects, and before putting on gloves. She also indicated staff needed to sanitize knives by use of a dishwasher before use on food.</p> <p>3.1-21(i)(3)</p>		<p>done by Dietary manager with staff #4, # 5 and #6</p> <ul style="list-style-type: none"> · Dietary manager/Designee will monitor 2 staff every shift for proper hand washing and glove use and utilize short form sanitation check twice weekly storage of clean utensils and meal observation check · Staff not adhering to policy will receive education, disciplinary action up to and including termination <p>4. How the corrective action will be monitor to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place</p> <ul style="list-style-type: none"> · To ensure compliance the Dietary manager/Designee will monitor 2 staff every shift using the short form sanitation check and meal observation CQI weekly X 4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. · If threshold of 100% is not achieved, an action plan will be developed to assure compliance. <p>5. Date of compliance July 10th, 2013</p>				

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F000431 SS=D	<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 and interview, the facility failed to label medication with the date it was first opened for use, for 3 residents and 1 stock</p>	F000431	<p>F 431</p> <p>1. What corrective action(S) will be accomplished for those residents found to have been affected by deficient practices.</p>	07/10/2013			

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	<p>medication in 1 of 1 of medication refrigerators in 1 of 1 medication room. (Residents #145, #228, and #229)</p> <p>Findings include:</p> <p>In an interview on 6/7/13 at 1:34 P.M., the Director of Nursing indicated there was only one medication storage room in the building.</p> <p>On 6/7/13 at 1:36 P.M., the following medications were observed in the refrigerator in the medication room:</p> <p>A. Resident #145--Vancomycin 250 mg. (milligrams)/10 ml. (milliliters) oral liquid suspension. B. Resident #229--Mary's Magic Mouthwash. C. Resident #228--Metoprolol 5 mg./ml. oral liquid D. Aplisol (House Stock), tuberculosis testing serum.</p> <p>All three bottles of liquid medications had the seals broken, and were partially full. There was no date on the label or any place on the bottles that indicated when they had first been opened. The vial of Aplisol was missing the protective metal covering over the rubber stopper, which indicated some of the medication had</p>		<ul style="list-style-type: none"> · Resident #145, #228 and #229 now has medications label with date opened. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken · All residents have the potential to be affected · Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding medication label with date when opened. · DNS/Designee audit the medication room refrigerator and med cart to ensure all open medications has date opened on them. 3. What measure will be put into place or what systemic changes will be made to ensure that deficient practice does not recur. · Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding medication label with date open. · Unit managers will check medication room refrigerator and med cart 3 times weekly for medication label open with date · Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination 4. How the corrective action will be monitor to ensure the deficient 				

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	<p>been withdrawn through the stopper for administration. There was no "opened" date on the vial or the plastic bag in which it was kept.</p> <p>The Director of Nursing checked the bottles and vial, but could not find an "opened" date for above medications.</p> <p>3.1-25(j)</p>		<p>practice will not recur i.e. what quality assurance program will be put in place</p> <ul style="list-style-type: none"> To ensure compliance the DNS/Designee will monitor medication label open date with medication storage CQI weekly X 4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance. <p>5. Date of compliance July 10th, 2013</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 record review, the facility failed to</p>	F000441	F 441 1. What corrective action(S) will be accomplished	07/10/2013			

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	<p>ensure linens were handled properly and failed to ensure handwashing was performed during personal care for 1 of 1 resident observed during incontinence care. (Resident #146, and CNA #1)</p> <p>Findings include:</p> <p>On 6/7/13 at 12:54 P.M., CNA #1 was observed in the bathroom for Resident #146. She put water in the sink and placed some washcloths with soap on them in warm water. The CNA then donned gloves without washing her hands, and provided incontinence care for loose bowel movement and urine. Without changing her gloves or washing her hands after finishing the incontinence care, CNA #1 placed a clean adult brief on the resident and changed his shirt and pants. She made the resident's bed with clean sheets, touched the resident's arms, and touched the wheelchair handles, handlebars, touched the closet doorknob, and grabbed unused clean towels. She then took the resident via wheelchair into the activity room.</p> <p>In an interview on 6/10/13 at 1:00 P.M., RN #3 indicated the process CNAs should follow when providing incontinence care was: they should</p>		<p>for those residents found to have been affected by deficient practices. · CAN #146 was given a one-on-one coaching on hand washing and handling of used linen. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken · All residents have the potential to be affected· Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding hand washing and handling of used linen. 3. What measure will be put into place or what systemic changes will be made to ensure that deficient practice does not recur. · Staffs were in-serviced by Staff development coordinator on June 19 th , and June 20, 2013, regarding hand washing and handling of used linen· DNS/Designee will monitor 2 staff every shift per week using the Infection control CQI tool· Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination 4. How the corrective action will be monitor to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place · To ensure compliance the DNS/Designee will monitor 2 staff every shift per week using</p>				

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	<p>wash their hands, put on gloves, wipe with toilet paper, then wash with soap and water, rinse and dry the resident. She indicated soiled wash cloths should be put into a plastic bag. She indicated when care was provided, they needed to wash their hands.</p> <p>The "CNA Skills Validation for Perineal Care" form, provided by RN #3 on 6/10/13 at 1:10 P.M., indicated "... 3. Wash hands. 4. Put on gloves. ... 7. Fill wash basin with warm water. ... 28. Remove gloves. 29. Wash hands...."</p> <p>3.1-18(l)</p>		<p>Infection control CQI tool weekly X 4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance. 5. Date of compliance July 10th, 2013</p>		