

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2014
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NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00136400.</p> <p>Complaint IN00136400-Substantiated. Federal/State deficiencies related to the allegation are cited at F314 and F353.</p> <p>Survey dates: January 7, 8, 9, 10, 13, 14, 15, and 16, 2014.</p> <p>Facility number: 000115 Provider number: 155208 AIM number: 100291080</p> <p>Survey Team: Sunny Jungclaus, RN TC Diana Sidell, RN Jennifer Carr, RN (January 7, 9, 10, 13, 14, 15, and 16, 2014) Julie Dover RN</p> <p>Census bed type: SNF/NF: 62 Residential: 8 Total: 70</p> <p>Census payor type: Medicare: 9</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 correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of this survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves 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, please feel free to contact me.</p>	

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

TITLE

(X6) DATE

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

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	<p>Medicaid: 50 Other: 11 Total: 70</p> <p>Residential Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</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 record review and interview, the facility failed to ensure a resident had fall risk assessments and side rail assessments. This</p>	F000272	F 272: Requires the facility to conduct initially and periodically comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity. 1.	02/06/2014

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	<p>affected 1 of 25 residents who fit the criteria for assessments. (Resident #66)</p> <p>Findings include:</p> <p>Resident #66's record was reviewed on 1/14/14 at 10:24 a.m. The record indicated Resident #66 had diagnoses that included, but were not limited to, depression, hypothyroidism, morbid obesity, high blood pressure, urinary frequency, chronic leg pain, gastro-esophageal reflux disease, hypokalemia, chronic obstructive pulmonary disease, and congestive heart failure.</p> <p>A care plan, dated 11/26/13, and updated on 1/1/14, indicated a problem of: "The resident has multiple risk factors for falls, such as: (refer to fall risk assessment) Impaired balance, unsteady gait, antidepressant use, cardiovascular med use, diuretic use, narcotic use, congestive heart failure, high blood pressure, assistance with activities of daily living, bowel incontinence, neuropathy, impaired vision, cognitive loss, urinary tract infection, pain, altered lab values." Interventions included, but were not limited to, "...Complete fall risk assessment upon admission,</p>		<p>Resident # 66 fall risk assessment and side rail assessment were completed on 1/29/14.2. In an effort to identify any other concerns, 100% audit of all current residents' charts will be reviewed to include fall risk and side rails assessments. Should concerns be observed, corrective action will be taken.3. All residents have the potential to be affected, thus, the following corrective actions have been taken: All nursing staff in-serviced on the importance of fall risk assessments and side rail assessments being completed upon admission (See attachment A). All newly admitted residents will have fall risk and side rail assessment completed upon admission. The records of newly admitted residents will be reviewed on the next business day following admission to determine assessments have been completed, and admission checklist will be reviewed (See Attachment B). As a means to ensure ongoing compliance, the DON or designee will monitor for compliance with completion of fall risk assessments and side rail assessments and quarterly review thereafter by random monitoring of at least 5 resident records, daily times four weeks on scheduled work days, weekly times four weeks, monthly times two months then quarterly until compliance is maintained. 4. As a means of quality assurance,</p>		

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	<p>quarterly, and with any significant change...1/2 side rails X2 to bed to aide in turning and repositioning."</p> <p>An incident and accident report and investigation, dated 1/1/14 at 9:00 p.m., indicated a CNA (name unknown) was transferring Resident #66 from a bedside commode to the bed and the resident's legs gave out and she fell on her buttocks. The resident's left arm hit the side rail on the bed. The CNA indicated, in the investigation, that the resident did not hit her head. The resident did have a skin tear and a bruise, had been wearing non-skid footwear, and a new intervention was put in place.</p> <p>Resident #66 did not have a fall risk assessment completed at admission or after the fall on 1/1/14.</p> <p>Resident #66's record contained a blank side rail assessment form.</p> <p>A physician's order, dated 11/19/13, indicated an order for: "Resident may use 1/2 siderails for bed repositioning."</p> <p>On 1/8/14, at 4:24 p.m., Resident #66 was observed in bed with half rails raised on each side of the bed.</p>		<p>the aforementioned audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted (See Attachment C). Completion Date: February 6, 2014.</p>		

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	<p>On 1/16/14, at 2:35 p.m., Resident #66 was observed in bed with half rails raised on each side of the bed.</p> <p>On 1/14/14 at 12:02 p.m., the DoN indicated there was no fall risk assessment nor a side rail assessment.</p> <p>3.1-31(d)(1)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a plan of care which reduced or removed the underlying risk factors related to pressure ulcers for one of 4 residents reviewed for pressure ulcers. (Resident #A).</p> <p>Findings include:</p> <p>Resident #A's closed record was reviewed on 1/13/14 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, diabetes,</p>	F000279	F279: Requires the facility develop a plan of care which reduced or removed the underlying risk factors related to pressure ulcers. 1. Resident A no longer resides at the facility, thus, no further action can be taken relative to the plan of care. 2. In an effort to identify all residents potentially affected, 100% audit of all current residents' charts to include review of Braden scale and identified risk will be conducted to ensure proper care plan is in place in response to the risk identified via scale. 3. As a means to ensure ongoing compliance, all	02/06/2014	

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	<p>depression, hypertension, stroke, and urinary incontinence. His quarterly Minimum Data Set (MDS), dated 6/10/13, indicated that his cognition was "severely impaired; rarely/never makes decisions."</p> <p>A further review of his MDS indicated a "significant change" on 9/10/13, which indicated that he had 2 stage II pressure ulcers not present on prior admission. The date of the oldest stage was indicated to be 9/7/2013. The MDS further indicated that the resident had "MASD" (Moisture Associated Skin Damage).</p> <p>A "Braden Scale for Predicting Pressure Sore Risk" was completed on 8/28/13, one day following re-admission, and indicated that Resident #A was at high risk for developing pressure ulcers. No further Braden Scales were completed for Resident #A.</p> <p>No care plans related to either reducing Resident #A's pressure ulcer risk prior to the documented development of pressure ulcers, or treating pressure ulcers once recognized were located in the resident's medical record.</p>		<p>nursing staff in-serviced on the importance of care plans and Braden scales being completed upon admission. (See attachment A). All newly admitted residents will be reviewed on the next business day following admission to confirm a Braden scale has been completed and plan of care written to address risk identified on the scale. (See Attachment B). Any newly identified skin concerns will be reviewed in stand up meeting and care plans reviewed and/or updated as appropriate. 4. As a means of quality assurance, the DON or designee will monitor for ongoing compliance with development of a care plan in response to identified risk of skin breakdown via random audits of at least 5 careplans daily times four weeks on scheduled work days, weekly times four weeks, monthly times two months then quarterly until compliance is maintained. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. (See Attachment C). Completion date: February 6, 2014.</p>		

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	<p>During an interview with the Director of Nursing (DoN) and the Assistant Director of Nursing (ADoN) on 1/15/14 at 2:15 p.m., they indicated that Resident #A did develop 2 pressure ulcers following his re-admission on 8/27/13. They further indicated that they could not provide any additional documentation regarding care plans for pressure ulcer risk and/or treatment.</p> <p>Following a review of Resident #A's entire medical record (including previous admissions) on 1/15/14 at 4:10 p.m., the Director of Medical Records indicated that she could not locate any additional care plans.</p> <p>A copy of the "Skin Management Program" (last review 11/20/2013) was provided by the Administrator on 1/13/14 at 9:45 a.m. The policy indicated, "The plan of care will be developed or reviewed following each completion of the Braden Scale by the care plan team."</p> <p>3.1-35(a)</p>			

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F000314 SS=E	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>A. Based on record review and interview, the facility failed to ensure that a resident did not develop pressure wounds while in the facility. This affected 1 of 2 residents reviewed for pressure ulcers in a sample of 7. (Resident #A)</p> <p>B. Based on record review and interview, the facility failed to follow their policy and procedure for daily wound monitoring for 5 of 7 residents who fit the criteria for pressure ulcers. (Resident # A, B, C, 7, and 87)</p> <p>Findings include:</p> <p>A. Resident #A's closed record was reviewed on 1/13/2014 at 12:00 p.m. He was re-admitted to the facility on 8/27/2013, following a hospital</p>	F000314	F 314: Requires the facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. Resident A no longer resides at the facility, thus, no further action can be taken. The skin conditions of the remaining residents listed who still reside at the facility were reviewed to ensure current measurements/descriptions are accurate in an effort to proceed with wound monitoring as described in the facility policy and procedure.2. All residents have the potential to be affected, thus, the following corrective actions have been taken. All nursing staff in-serviced on the importance of daily wound	02/06/2014			

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	<p>admission on 8/21/13 for lethargy, confusion, and weakness. Resident #A began receiving "end of life" care on 9/13/2013 and expired 9/14/2013. Diagnoses included, but were not limited to, dementia, diabetes, depression, hypertension, stroke, and urinary incontinence. His quarterly Minimum Data Set (MDS), dated 6/10/2013, indicated that his cognition was "severely impaired; rarely/never makes decisions."</p> <p>A further review of his MDS indicated a "significant change" on 9/10/13, which indicated that he had 2 stage II pressure ulcers not present on prior admission. The date of the oldest stage was indicated to be 9/7/2013. The MDS further indicated that the resident had MASD (Moisture Associated Skin Damage).</p> <p>The "Resident Admission Assessment" form, dated 8/27/13, indicated under Body (skin): "See skin sheets." Nurse's Notes dated 8/27/2013 at 5:00 p.m. indicated, "Res (resident) admitted ...Skin assessment done - see skin sheets." No additional documentation regarding skin assessments/skin sheets was located for that date.</p>		<p>monitoring including following the policy and procedure in regard to Skin Management. 100% audit of all current residents' charts with current skin breakdown will be completed to ensure accurate measurement/description of skin conditions. (See attachment A).3. As a means to ensure ongoing compliance with ensuring residents do not develop pressure wounds unless unavoidable and ensuring the facility follows its policy regarding daily wound monitoring, skin assessments of all newly admitted or readmitted residents will be reviewed on the next business day following admission/re-admission to confirm Braden scale completion and accurate identification of skin risk and/or existing areas, as well as ensure the plan of care is in place in response to said areas and/or risk of breakdown (See attachment B)4. As a means of quality assurance, the DON or designee will monitor for ongoing compliance with the skin management policy and procedure daily on scheduled work days. Should concerns and/or non-compliance be noted, corrective action shall be taken. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. (See Attachment C). Completion Date: February 6, 2014.</p>		

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	<p>A "Braden Scale for Predicting Pressure Sore Risk" was completed on 8/28/2013, indicating that Resident #A was at high risk for developing pressure ulcers. No further Braden Scales were completed for the resident.</p> <p>The "Interdisciplinary Care Plan Conference Record", dated 8/29/13, indicated that only 1 Social Services staff member, 1 Activities staff member and 1 Dietary staff member were present. The section indicating "[] Skin Condition: presence or absence of pressure ulcers addressed (including risk and approaches such as pressure redistribution devices or equipment, turning/repositioning, or weight shifting to prevent or address pressure ulcers)" was blank.</p> <p>A " Weekly Skin Assessments " flow sheet had consecutive entries dated 9/6/2013 and 9/13/2013. Both indicated " Head to toe skin assessment completed. No new skin alterations noted (see existing appropriate skin flowsheet for existing alteration). "</p> <p>A "Skin Condition Flowsheet for Non-pressure Related Skin Conditions", initiated 9/7/2013,</p>						

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	<p>indicated 2 "fragile" areas on Resident #A's "Left inner and upper buttocks. Right buttocks", which were "Acquired after admission". The documented size was "1x1cm". The next entry was dated 9/13/2013 and indicated the size to be "2cm x 1cm". Progress of the noted area(s) was documented as "Deteriorated".</p> <p>A "Skin Condition Flowsheet for Non-pressure Related Skin Conditions", initiated 9/7/2013, indicated "Excoriation" on the coccyx, which was "Acquired after admission". No documentation of size was noted. The next entry was dated 9/13/2013 and indicated the size to be "3cm x 2cm". Progress of the area was documented as "Deteriorated". The wound was described to be "purple". Surrounding skin was described to be "red/purple". Additional comments indicated, "End of life - skin with appearance of Kennedy ulcer."</p> <p>All "Medicare Documentation Worksheet" nursing assessments and "Nursing Progress Notes" from 8/27/2013 through 9/14/2013 (when Resident #A expired) were reviewed. "Medicare Documentation Worksheet" nursing assessments</p>			

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	<p>consistently indicated "Skin Condition" as "warm" and "dry", with no "Additional comments". " Nursing Progress Notes " did not address pressure ulcer risk, assessment, or treatment.</p> <p>During an interview with the Director of Nursing (DoN) and the Assistant Director of Nursing (ADoN) on 1/15/2014 at 2:15 p.m., they indicated that Resident #A developed "2 pressure areas" following his re-admission on 8/27/2013. They further indicated that they could not provide any additional documentation regarding initial skin assessments, Braden Scales completed after 8/28/2013, daily skin assessments following initial documentation of pressure areas on 9/7/2013, or additional Interdisciplinary Care Plan Conference Records.</p> <p>A copy of the "Skin Management Program" (reviewed 11/20/2013) was provided by the Administrator on 1/13/14 at 9:45 a.m. The policy included, but was not limited to, the following:</p> <ol style="list-style-type: none"> 1. "A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, 						

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NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
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	<p>readmission and at least weekly thereafter."</p> <p>2. "Daily documentation will be completed on all open areas related to pressure, venous, arterial and diabetic wounds using the form Pressure, Venous, Arterial & Diabetic Ulcer Daily Monitoring."</p> <p>3. "The Braden Scale will be completed upon admission/readmission, weekly for 4 weeks post-admission/readmission, quarterly and with significant changes in condition (as defined by the RAI manual) to determine the individual's risk factors."</p> <p>During an interview with the DoN on 1/14/13 @ 3:20 p.m., regarding the "Pressure, Venous, Arterial & Diabetic Ulcer Daily Monitoring Form", as indicated in the policy and procedure, she indicated, " We don't do that. I'm going to take that out of there." She further indicated that she "does rounds" routinely on residents with pressure ulcers, but does not document her findings anywhere.</p> <p>On 1/16/2014 at 5:15 p.m., the DoN was interviewed regarding the Interdisciplinary Care Team (IDT).</p>			

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	<p>She indicated that there was no nurse present during the 8/28/2013 IDT meeting. She further indicated, " We usually try to have a nurse there. "</p> <p>B.1. Resident #C's record was reviewed on 01/13/14, at 11:39 a.m. The record indicated Resident #C was admitted with diagnoses that included, but were not limited to, schizophrenia, Parkinsons, dementia, tartive dyskinesia, benign prostatic hypertrophy, chronic obstructive pulmonary disease, coronary artery disease, urinary retention, and urinary tract infection.</p> <p>A Pressure Ulcer Flowsheet, dated 05/20/13, indicated Resident #C had a right heel ulcer sized at 4.0 by 4.0 centimeter black eschar (no staging information was noted).</p> <p>During an interview on 01/14/14 at 2:51 p.m., LPN #13 indicated that as far as she knew before the right heel area had been found that Resident #C's weekly skin checks were ok and resident was wearing his foam boots. LPN #13 also indicated that Resident #C's ulcer had been slow to heal and they had been using different treatments to address this.</p> <p>An ultrasound report for bilateral</p>				

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	<p>heels dated 08/09/13 indicated that there was "Moderate diffuse bilateral peripheral vascular disease without definite focal stenosis identified."</p> <p>Review of the Pressure Ulcer Flowsheets showed that the right heel ulcer on 05/20/13 was unstageable, with size of 6.5 by 6.0 centimeters with depth at greater than or equal to 0.1 centimeter and an 01/09/14 notation the ulcer was stage 2 with size at 3.2 by 1.1 centimeters with depth 0.2 centimeters.</p> <p>No daily right heel pressure ulcer documentation for Resident #C was found in the resident's record or use of the form "Pressure, Venous, Arterial & Diabetic Ulcer Monitoring".</p> <p>B.2. Resident #B's record was reviewed on 01/15/14, at 3:10 p.m. The record indicated Resident #B was admitted with diagnoses that included, but were not limited to, left knees replacement, sepsis, gastroesophageal reflux disease, high blood pressure, coronary artery disease, pancreatitis, osteoarthritis, anxiety, and diabetes.</p> <p>A "Resident Admission Assessment" dated 08/30/13, indicated Resident</p>			

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	<p>#B was admitted with a 1.0 by 1.0 centimeter (no staging information was noted) coccyx pressure ulcer, and a stage 2 size 3.0 by 3.0 centimeter coccyx pressure ulcer.</p> <p>A Pressure Ulcer Flowsheet dated 09/27/13, indicated that the 1.0 by 1.0 centimeter ulcer was now 0 size/area closed/will continue to monitor. A Pressure Ulcer Flowsheet dated 09/10/13, indicated that the 3.0 by 3.0 centimeter open area is resolved.</p> <p>No daily right heel pressure ulcer documentation for Resident #B was found in the resident's record or use of the form "Pressure, Venous, Arterial & Diabetic Ulcer Monitoring".</p> <p>B.3. Resident #7's record was reviewed on 01/14/14, at 9:31 a.m. The record indicated that Resident #7 was admitted with diagnoses that included, but were not limited to, immobility, dialysis, renal failure, acute kidney injury, diabetes, diabetic neuropathy, high blood pressure, gastroesophageal reflux disease, chronic obstructive pulmonary disease, stroke, seizures, depression, hypothyroid, congestive heart failure, and bipolar.</p>			

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	<p>A "Resident Admission Assessment" dated 12/24/13, indicated Resident #7 was admitted with a stage 1 size 1.0 by 1.0 centimeter with no depth pressure ulcer on her left heel.</p> <p>A "Pressure Ulcer Flowsheet" dated 01/09/14, indicated that the left heel pressure ulcer was stage 1 size 1.5 by 0.5 centimeter with no depth with color of red/purple non-blanchable erythema (redness).</p> <p>No daily right heel pressure ulcer documentation for Resident #7 was found in the resident's record or use of the form "Pressure, Venous, Arterial & Diabetic Ulcer Monitoring.</p> <p>B.4. Resident #87's record was reviewed on 1/10/14, at 10:15 a.m. The record indicated Resident #87 was admitted with diagnoses that included, but were not limited to, hypernatremia, subarachnoid hemorrhage with aphasia, chronic obstructive pulmonary disease, high blood pressure, type two diabetes mellitus, high blood fats, and esophagitis.</p> <p>A "Resident Admission Assessment" dated 10/14/13, indicated Resident #87 was admitted with a 1.1 by 1</p>				

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	<p>centimeter stage 2 pressure ulcer on the coccyx.</p> <p>A "Braden Scale - for predicting pressure sore risk" was completed on admission, and the total score was 14, which indicated a moderate risk for developing pressure ulcers.</p> <p>An initial care plan, dated 10/14/13, indicated: "At risk for alteration in skin integrity R/T: incontinence. Goal: Resident will be free from skin breakdown thru next review. Interventions: Assess skin daily for signs of breakdown and report to MD and responsible party as needed...."</p> <p>A "Pressure Ulcer Flowsheet", dated 10/30/13, indicated there were 2 stage 2 pressure ulcers, one was 3 cm by 1.8 cm, and the other was 3 cm X 1.8 cm, and described as red with tape shear areas, and the wound bed was covered with fine light yellow slough, the edges very red, and the treatment was enlutra.</p> <p>A "Pressure Ulcer Flowsheet", dated 11/5/13, indicated Resident #87 had 2 stage 2 pressure areas, 3 cm by 1.8 cm, and red, and 3 cm X 1.8 cm. The treatment had been changed to mepilex.</p>				

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	<p>On 11/6/13, the "Pressure Ulcer Flowsheet" indicated the areas had combined into a stage 3 pressure ulcer, and was 7.3 X 3.2 cm, with brown eschar, and the wound edges were red. The flow sheet indicated: "Wound bed [with] 50% yellow/brown eschar 25% light yellow slough & 25% pink wound tissue - Both areas have combined to 1 lg area."</p> <p>On 11/21/13, the area on the coccyx was unstageable, measured 1.8 by 1.5 cm, moderate serous drainage with no odor. The wound bed had slough and black/brown eschar with red wound edges. The treatment had been changed to santyl/mepilex silver.</p> <p>On 11/29/13, the pressure ulcer on the coccyx was unstageable, and measured 3.5 cm by 2.8 cm.</p> <p>On 12/5/13, the pressure ulcer was unstageable and measured 4.3 by 3.3, with a 50% beef red wound bed and 50% white tissue noted on the left half of wound.</p> <p>Observations of Resident #87, on 1/8/14, 1/9/14, 1/13/14, and 1/14/14, indicated he was turned at least</p>				

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	<p>every 2 hours, and would lay side to side unless up in a geri chair, then he would be slightly reclined on his back and sitting up.</p> <p>The resident's record failed to indicate, on the following days, that a skin assessment had been done: 10/15/13, 10/16/13, 10/17/13, 10/18/13, 10/19/13, 10/21/13, 10/22/13, 10/23/13, and on 11/30/13.</p> <p>This Federal tag relates to Complaint IN00136400.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>						

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to obtain a physician's order for administration of influenza vaccine. This affected 1 of 5 residents reviewed for influenza in a sample of 5. (Resident #41)</p> <p>Findings include:</p> <p>The clinical record for Resident #41 was reviewed on 01/13/14 at 11:27 a.m.</p> <p>The Influenza Vaccine Consent information and signature form,</p>	F000334	F334: Requires the facility to obtain a physician's order for administration of the influenza vaccine. 1. The physician of Resident # 41 was in agreement with administration of the influenza vaccine and provided an order reflecting the same.2. All residents have the potential to be affected thus; the following corrective actions have been taken. 100% audit of all residents was completed to ensure all residents given the vaccine had not only consent, but also a physician's order. No others were found to be affected.3. In an effort to ensure ongoing compliance, applicable staff have	02/06/2014	

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	<p>dated 08/20/13, had the resident's daughter's signature which gave permission for the facility to administer the Influenza Vaccination.</p> <p>"The Immunization Record Certificate of Immunization" form indicated that Resident #41 received an immunization to Left Deltoid with signature of the DoN.</p> <p>The Medication Administration Record for Resident #41, dated 10/01/13 through 10/31/13, indicated the DoN had given the flu shot on 10/14/13, and was initialed by the DoN.</p> <p>No order was found in Resident #41's chart for Resident #41 to receive an influenza vaccination.</p> <p>In an interview on 01/15/13, at 10:25 a.m., RN #1 indicated after she reviewed the physician order forms for Resident #41, that there was no physician order for Resident #41 to have an influenza vaccination and that it appeared that all of the resident's orders were in her record. The DoN concurrently checked Resident #41's physician orders and she also indicated that there was no order for the resident to have an</p>		<p>been addressed as to the necessity of a physician's order (in addition to consent) prior to administration of the vaccination. The orders of each newly admitted resident will be reviewed by the DON or designee on the next business day following admission to confirm the presence of an order prior to vaccination administration.4. As a means of quality assurance, the DON or designee will monitor for compliance with the presence of an order prior to vaccination administration, as described, ongoing. Should non-compliance be observed, corrective action shall be taken. The monitoring and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. (See Attachment C).Completion Date: February 6, 2014</p>		

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	<p>influenza vaccination.</p> <p>A policy and procedure titled "Annual Influenza Immunization Procedure" received 01/07/14, at 3:48 p.m., from the Administrator, indicated: "Policy: To administer influenza vaccines to all residents on an annual basis according to guidelines set forth by state regulations, unless medically contraindicated. Procedure: 1. On an annual basis, the facility will confirm orders for administration of the influenza vaccine...."</p> <p>3.1-3(a)</p>			
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F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to ensure sufficient nursing staffing to meet the needs of the residents. This deficient practice has the potential to adversely affect all 62 residents residing in the skilled and intermediate part of the facility. (Residents #H)</p> <p>Findings include:</p> <p>During an interview on 1/9/14 at</p>	F000353	F 353: Requires the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 1. It is the goal of the facility to provide services to its residents to allow the resident to attain or maintain their highest practicable physical and psychosocial well-being. 2. As all residents have the potential to be affected, the following	02/06/2014	

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	<p>11:41 a.m., a family member indicated that on Christmas Eve they only had one aide and family had to pull the resident up, (the resident had scooted down in bed and needed to be pulled back up) they didn't have enough help.</p> <p>On 1/9/13 at 2:02 p.m., Resident #H indicated "they need more staff, they have to lift me and it takes 3 people, sometimes it is hard to find 3 people. Call lights take between 5 and 15 min to answer. One time I had to wait so long to go to the bathroom that I was incontinent, both of bowel and bladder."</p> <p>During an interview with confidential staff member #A, at a confidential date and time, the staff member indicated they can get their assignments completed if they only have one assignment, (an assignment is the care load for one CNA or nurse) but sometimes they have two assignments. The staff member indicated at times there is only one person for an entire wing if they have call ins, and there isn't enough staff; they get everything done, but doesn't see how they do it.</p> <p>On 1/13/14, at 9:57 p.m., the following was observed: 1 CNA on</p>		<p>corrective actions have been taken. 3. The facility has placed an ad in the local paper to recruit staff in an effort to reduce the amount of overtime and possible burnout. Administration and nursing administration have met to review current acuity and staffing patterns in an effort to ensure staff are best utilized in response to residents' plans of care. Nursing management has been re-educated on assessing the need for a sufficient amount of staff to care for the residents. (See attachment D)4. As a means of quality assurance, and in an effort to ensure a sufficient amount of staff is present, the administrator or designee will complete the staffing PPD daily for 4 weeks, then weekly for four weeks, monthly times two and then quarterly until compliance is maintained. (See attachment E). Daily rounds on scheduled days of work will be conducted in an effort to assess sufficiency of staff as evidenced by ability to care for the residents according to their careplans and provide timely response to resident needs. Results of the rounds, PPD reviews and any additional corrective action taken shall be reported to the Quality Assurance Committee during quarterly meetings and the plan revised, if warranted. Completion Date: February 6, 2014.</p>				

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	<p>wing 2, the nurse on wing 4 is also the nurse for wing 2. One CNA stays on wing 2 but the nurse floats. There were 19 residents on wing 2. One CNA was on wing 3 and one on wing 4. Wing 4 had 15 residents. Confidential staff member #B indicated, on a confidential date and time, "It's the way they staff. On wing 3, they have 28 residents. Most of residents for safety reasons require 2 CNAs, some require the hoyer lift and the nurse can't help if she is giving medications."</p> <p>Confidential staff member #C indicated, on a confidential date and time; "it wasn't fair that some staff stay over to help, on weekends it is always like that - they work the staff like this all the time. They don't have time to get everything cleaned up right, like meal trays, because one aide has to stay on the floor."</p> <p>During an interview on 1/13/14, at 10:24 p.m., CNA #D indicated "they have a nurse who goes back and forth between wing 2 and wing 4, so 60% of the time the CNA is by herself on wing 2. I have 19 residents, I do bed checks every 2 hours, pass ice water, and wash wheel chairs. I do a walk through when I first come in, and in between</p>						

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	<p>bed checks I walk around and check on the residents. I have 1 resident I need help with at times and I call another CNA, (from another wing) or the nurse to help. It takes 20 to 40 minutes to do a bed check, depending on how many residents need assistance. I have 3 residents I get up for breakfast and 1 I get up with help if I have time; I have time to get everything done, I have a routine."</p> <p>During an interview with confidential staff member #E, she indicated there were 2 nurses and 3 aids for the whole building one night. She indicated they get everything done but they hurry, they have to rush, they can't do things at a normal pace. The STAR program is supposed to be used for call ins, to replace call ins, but they use it to replace holes in the schedule. Until a couple of weeks ago, they only had 1 aide on wing 4. She said they have one resident who requires two to turn, so the CNA and nurse always turns him together.</p> <p>On 1/13/14 at 11:00 p.m.,CNA #F indicated she is staying over until 2 p.m. tonight, and that most have to stay over due to call ins, or not enough scheduled staff.</p>			

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	<p>The census and condition form was provided by the Administrator on 1/7/14 at 3:48 p.m. The census and condition indicated the facility had 62 residents on the healthcare side, 0 residents were independent with bathing, 44 residents required the assist of 1 or 2 staff for bathing, and 14 were totally dependent on staff for bathing. For dressing, 8 were independent, 39 required 1 to 2 assist, and 11 were totally dependent on staff. For transfers, 10 were independent, 26 required 1 to 2 assist, and 21 were totally dependent on staff. For toileting, 7 were independent, 32 required 1 to 2 assist, and 20 were dependent on staff. For eating, 23 were independent, 20 required assist for eating, and 16 were totally dependent on staff for eating.</p> <p>On 1/16/14 at 11:08 a.m., the Administrator indicated they staff differently on each shift, they staff by census and level of care; how many residents in facility are 2 assists or 1 assist. They staff by behaviors, residents who have behaviors, and if there are other problems like the water problem. The nurses help on the floor also. The Corporate Nurse Consultant indicated they have</p>			
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F000372 SS=E	<p>ancillary staff that assist with residents too, like physical therapy, occupational therapy, and restorative aides. Restorative aides help with call lights, dressing and grooming, get people up, activities of daily living, transfers, it depends on what program they are on. They come in early in the morning, the last part of 3rd, days, and the first part of 2nd.</p> <p>This Federal tag relates to Complaint IN00136400.</p> <p>3.1-17(a) 3.1-17(b)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.</p>	F000372	F 372: Requires the facility to	02/06/2014

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	<p>Based on observation and interview, the facility failed to ensure garbage was disposed of properly in that garbage was scattered in the vicinity of two of two dumpsters. This had the potential to affect 70 residents currently residing in the facility.</p> <p>Findings include:</p> <p>On 1/13/14 at 2:58 p.m., the dumpster area was observed with the Dietary Manager. Two dumpsters sat side by side in an area that had a high wooden fence that encompassed the dumpsters. In the area behind the dumpsters were multiple plastic spoons, forks, knives, plastic gloves, wrappers, plastic bags, an empty potato chip can, an old straw broom, and the metal support part of an overbed table.</p> <p>In the grassy area on the right side of the dumpsters, multiple straws, plastic spoons, forks, knives, gloves, wrappers, plastic bags and other paper debris were observed in the grass.</p> <p>The Dietary Manager indicated the dumpsters had been moved earlier that morning but they had not been</p>		<p>ensure garbage is disposed properly. 1. The area surrounding the dumpster area was policed and debris discarded.2. Per facility rounds, no other concerns with proper disposal were identified.3. As a means to ensure ongoing compliance to ensure garbage is disposed properly, Staff were in-serviced on the proper way to dispose of trash and police surrounding area on 1/23/2014. (See Attachment F). Dietary and/or Maintenance will monitor the dumpster area on work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. Should non-compliance be observed, corrective action shall be taken. 4. As a means of quality assurance, the aforementioned audits/monitoring and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. (See attachment G). Completion Date: February 6, 2014.</p>		

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	<p>able to clean the area yet. The Dietary Manager also indicated the dietary, maintenance, and housekeeping departments are responsible to keep the area clean.</p> <p>During an interview on 1/14/14 at 10:50 a.m., the Administrator indicated the dumpster area was last checked on 1/10/14, and indicated since it was cold and icy on that day, and very windy on Monday, 1/13/14, they hadn't been able to clean the area around the dumpster. The Director of Nurses indicated at that time she would look for a policy for the dumpster area, but no policy was provided.</p> <p>3.1-21(1)(5)</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 remove, and ensure the disposition of, expired medications. This deficiency had the potential to affect all of the residents in the facility.</p> <p>Findings include:</p> <p>On 1/14/14 at 9:55 a.m., an observation of the wing 4 medication room was conducted with RN #1. An open box of unit dose Afluria influenza vaccine (Lot # P511208) was observed to have an expiration</p>	F000425	F425: Requires the facility to provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in 483.75 (h) of the part. It further requires the facility to remove, and ensure this disposition of, expired medications. 1. The expired vaccinations were disposed upon discovery.2. All other storage areas were assessed to ensure no other expired medications were on site. 3. As a means to ensure ongoing compliance with ensuring the disposition of expired medications, Nursing staff were in-serviced on medication	02/06/2014			

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	<p>date of "exp 30June2013". RN #1 confirmed the expiration date and opened the box to reveal 3 doses remaining in the box of 10. She further indicated that third shift nurses are routinely responsible for removing expired medications from the medication room and that she did not know if any residents or staff received the expired vaccine.</p> <p>In an interview with the Administrator on 1/14/14 at 2:00 p.m., she indicated that she reviewed all influenza vaccines administered since 6/30/2013 and that no residents received the expired vaccine.</p> <p>A copy of "Storing Drugs" (last reviewed 11/20/2013), was provided by the Director of Nursing on 1/14/14 at 5:18 p.m. The policy indicated, "Any outdated, contaminated, or deteriorated drugs...must be removed from stock and destroyed according to procedures for drug destructions."</p> <p>3.1-25(o)</p>		<p>destruction of expired medications. (See attachment A)</p> <p>4. As a means of quality assurance, the DON or designee will monitor all medications rooms to ensure medication destruction of expired medications on work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. Should noncompliance be observed, corrective action shall be taken. Results of the audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. (See attachment H). Completion Date: February 6, 2014</p>		

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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 and interview,</p>	F000441	F441: Requires the facility to establish and maintain an	02/06/2014			

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	<p>the facility failed to ensure that staff members washed their hands for 4 of 4 observations. (Resident #7, #14, #93, and #98)</p> <p>Findings include:</p> <p>1. During a medication pass observation, on 1/14/14 at 8:40 a.m., RN# 1 did not wash or disinfect her hands prior to preparing or administering medication to resident # 98.</p> <p>2. Immediately following administration of medications to Resident #98, she administered medications to Resident #93. She was observed to not wash or disinfect her hands prior to preparing or administering oral medications. RN #1 did not wash or disinfect her hands prior to flushing the PICC (peripherally inserted central catheter) line or preparing of a new bag of peripheral parenteral nutrition (PPN) intravenous feeding, and tubing. Prior to connecting the PPN tubing to the PICC line, RN #1 was observed washing her hands for 4 seconds at 9:11 a.m., in Resident #93's bathroom, prior to donning clean gloves and connecting the PPN tubing to the resident's PICC line.</p>		<p>inflectional control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection.</p> <p>1. Applicable staff observed to have not washed/sanitized hands appropriately during medication pass and/or treatment application were identified and addressed.2. As all staff could be applicable, the following corrective actions were taken.3. As a means to ensure ongoing compliance, staff was in-serviced on the importance of hand washing and current policy regarding hand washing and hand hygiene reviewed with employees on 1/23/14. (See attachment F).4. As a means to ensure quality assurance, the DON or designee will observe an employee demonstrating correct procedures of handwashing during provision of care on work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. Should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. (See attachment I). Completion Date: February 6, 2014.</p>		

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	<p>3. During a med pass observation for Resident #14, on 1/15/14 at 11:50 a.m., RN #1 was again observed not washing or sanitizing her hands prior to beginning or at any time during preparation/dispense/administration of meds. RN #1 was sitting at the nurse's station charting, got up, pushed med cart down the hall to Resident # 14's room, prepped meds, knocked on door, entered, and administered.</p> <p>4. On 01/14/14 at 10:10 a.m., left heel wound care and right heel preventative care was observed for Resident #7. RN #1 was observed to not wash her hands directly before applying gloves to perform application of Sureprep skin preparation to the resident's heels. After finishing the procedure, RN # 1 was observed to not wash her hands after she removed her gloves and disposed of used package/gloves.</p> <p>In an interview with RN #1 following the care procedure, RN #1 indicated that she had washed her hands just before, in the Occupational Kitchen, and that she did not wash her hands after finishing the procedure.</p>			

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F000456 SS=E	<p>During an interview with DoN on 1/14/14, at 5:18 p.m., she indicated that handwashing is included in the infection control policy and no there is no additional policy for IV or PICC line administration/care. She indicated, "It's just nursing 101."</p> <p>3.1-18(l)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observation, interview and record review, the facility failed to maintain 1 of 3 medication refrigerators in the facility in a safe operating condition, which had the potential to impact all 26 residents on wing 3.</p> <p>Findings include:</p>	F000456	F456: Requires the facility maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 1. The medications housed in the refrigerator observed to be at sub temperature were discarded.2. All other refrigerators in use were assessed with no problems identified.3. As a means to ensure ongoing compliance with the storage of medications at the appropriate temperature, the	02/06/2014

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	<p>An observation of the wing 3 medication room, which holds medications for both wing 3 and the residential wing, was conducted with LPN #5 on 1/14/14 at 2:06 a.m. The refrigerator thermometer was observed to indicate 4 degrees Fahrenheit. The freezer thermometer was observed to indicate 18 degrees Fahrenheit. The "Refrigerator / Freezer Temperature Log" for January, 2014 indicated that the temperature was documented to be between 48 degrees Fahrenheit and 58 degrees Fahrenheit on January 1, 2014 through January 14, 2014.</p> <p>The "Refrigerator / Freezer Temperature Log" was observed to clearly indicate the following parameters:</p> <ol style="list-style-type: none"> 1. Refrigerator temperature: "(Normal Range >32 <40)" 2. Freezer temperature: "(Normal Range < 40)" <p>On 1/14/14 at 2:11 p.m., an inventory of the wing 3 medication room refrigerator was conducted with the Director of Nursing (DoN). The following medications for wing 3 residents were observed to be removed from the refrigerator by the</p>		<p>refrigerator in question was removed and a new refrigerator was purchased. The refrigerator that was removed was assessed for function and a new thermometer placed and found to be in good working order. Temperatures likely had not risen above 45 degrees as outlined in facility policy. Nursing staff was in-serviced on the policy of medication refrigerator temperatures on 1/23/14. (See attachment A).4. As a means of quality assurance, the medication refrigerator temperatures will be monitored by the DON or designee during work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. Should non-compliance be observed, corrective action shall be taken. The audits/monitoring and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. (See attachment J). Completion Date: February 6, 2014</p>				

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	<p>DoN, who indicated, "These are all no good. I'm throwing them away. Pharmacy can re-order them.":</p> <ol style="list-style-type: none"> 1. 1 Aplisol 5ml multi-dose vial, unopened, labeled "staff use only" 2. 1 Risperdal 50mg for intramuscular injection, unopened (Resident #48) 3. 1 Levemir 100u/ml unopened x 1 dose box unopened (Resident #6) 4. 12 Promethegan 25mg suppositories (Resident #6) 5. 10 Promethegan 25mg suppositories (Resident #4) 6. 10 Promethegan 25mg suppositories (Resident #49) 7. 2 Bisac-evac 10mg suppositories (Resident #49) 8. 10 Bisac-evac 10mg suppositories (Resident #1) 9. 1 vial Novalog 100u/ml insulin, unopened (No resident indicated) <p>The following medications were indicated in writing as the contents of the locked "Refrigerator EDK (Emergency Drug Kit) Kit #29", which the DoN indicated she would not open and would return to pharmacy:</p> <ol style="list-style-type: none"> 1. "Ativan intensol 2mg/ml 1x30ml" 2. "Ativan IM 2mg/ml x 5x 1ml" 3. "Phenergan supp 25mg x 5" 						

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	<p>4. "Dulcolax supp 10mg supp x 2"</p> <p>5. "Tylenol supp 650mg x 5"</p> <p>6. "Humalog 1 x 3ml"</p> <p>7. "Humulin N (AB rated Novolin N) 1 x 3ml"</p> <p>8. "Humulin R (AB rated Novolin R)"</p> <p>9. "Humulin 70/30 mix 1x3ml"</p> <p>10. "Lantus Solostar x 1"</p> <p>11. "Novolog flex pen x 1"</p> <p>"Refrigerator / Freezer Temperature Logs" for November, 2013 and December, 2013 were provided by the DoN on 11/14/13 at 5:18 p.m. The temperatures documented indicated that refrigerator temperatures did not rise above 40 degrees Fahrenheit or below 32 degrees Fahrenheit; and that the freezer temperatures did not rise above 0 degrees Fahrenheit at any time.</p> <p>The facility policy and procedure entitled "Storing Drugs" (reviewed 11/20/2013), provided by the DoN on 1/14/14 at 5:18 p.m., included, but was not limited to:</p> <p>"Drugs requiring storage in "A COOL PLACE" must be stored in a refrigerator designated for <u>medications only</u> and be maintained between 2 degrees Celsius (35 degrees Fahrenheit) and 8 degrees</p>						

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R000145	<p>410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on observation and record review, the facility failed to maintain a medication refrigerator, in a safe and operational condition. This deficient practice had the potential to impact 8 of 8 residents. (R#1, R#2, R#3, R#4, R#5, R#6, R#9, R#10)</p> <p>Findings include:</p> <p>An observation of the wing 3 medication room, which holds medications for both wing 3 and the residential wing, was conducted with LPN #5 on 1/14/14 at 2:06 a.m. The refrigerator thermometer was</p>	R000145	<p>plan of correction as our credible allegation of compliance. Due to the low scope and severity of this survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves 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, please feel free to contact me.</p> <p>R 145: Requires the facility to maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. 1. The medications housed in the refrigerator observed to be at sub temperature were discarded.2. All other refrigerators in use were assessed with no problems identified.3. As a means to ensure ongoing compliance with the storage of medications at the appropriate temperature, the refrigerator in question was removed and a new refrigerator was purchased. The refrigerator that was removed was assessed for function and a new</p>	02/06/2014	

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	<p>observed to indicate 4 degrees Fahrenheit. The freezer thermometer was observed to indicate 18 degrees Fahrenheit. The "Refrigerator / Freezer Temperature Log" for January, 2014 indicated that the temperature was documented to be between 48 degrees Fahrenheit and 58 degrees Fahrenheit on January 1, 2014 through January 14, 2014.</p> <p>The "Refrigerator / Freezer Temperature Log" was observed to clearly indicate the following parameters:</p> <ol style="list-style-type: none"> 1. Refrigerator temperature: "(Normal Range >32 <40)" 2. Freezer temperature: "(Normal Range < 40)" <p>On 1/14/14 at 2:11 p.m., an inventory of the wing 3 medication room refrigerator was conducted with the Director of Nursing (DoN). The following medications were observed to be removed from the refrigerator by the DoN and placed in the medication room sink:</p> <ol style="list-style-type: none"> 1. 23 Promethegan 25mg suppositories (#R3) 2. 1 multi-dose, open vial of individualized allergy medication, 		<p>thermometer placed and found to be in good working order. Temperatures likely had not risen above 45 degrees as outlined in facility policy. Nursing staff was in-serviced on the policy of medication refrigerator temperatures on 1/23/14. (See attachment A).4. As a means of quality assurance, the medication refrigerator temperatures will be monitored by the DON or designee during work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. Should non-compliance be observed, corrective action shall be taken. The audits/monitoring and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. (See attachment J). Completion Date: February 6, 2014</p>				

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	<p>labeled "Vial A" (#R10)</p> <p>3. 1 multi-dose, open vial of individualized allergy medication, labeled "Vial B" (#R10)</p> <p>4. 13 Promethazine 25mg suppositories (Resident #6)</p> <p>The DoN indicated of the above medications, "These are all no good. I'm throwing them away. Pharmacy can re-order them."</p> <p>The following medications were indicated in writing as the contents of the locked "Refrigerator EDK (Emergency Drug Kit) Kit #29", which the DoN indicated she would not open and would return to pharmacy:</p> <ol style="list-style-type: none"> 1. "Ativan intensol 2mg/ml 1x30ml" 2. "Ativan IM 2mg/ml x 5x 1ml" 3. "Phenergan supp 25mg x 5" 4. "Dulcolax supp 10mg supp x 2" 5. "Tylenol supp 650mg x 5" 6. "Humalog 1 x 3ml" 7. "Humulin N (AB rated Novolin N) 1 x 3ml" 8. "Humulin R (AB rated Novolin R)" 9. "Humulin 70/30 mix 1 x 3ml" 10. "Lantus Solostar x 1" 11. "Novolog Flex Pen x 1" <p>"Refrigerator / Freezer Temperature Logs" for November, 2013 and</p>						

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	<p>December, 2013 were provided by the DoN on 11/14/13 at 5:18 p.m. The documentation indicated that refrigerator temperatures did not rise above 40 degrees Fahrenheit or below 32 degrees Fahrenheit; and that the freezer temperatures did not rise above 0 degrees Fahrenheit at any time.</p> <p>The facility policy and procedure, entitled "Storing Drugs" (reviewed 11/20/2013), provided by the DoN on 1/14/14 at 5:18 p.m., included, "Drugs requiring storage in "A COOL PLACE" must be stored in a refrigerator designated for <u>medications only</u> and be maintained between 2 degrees Celsius (35 degrees Fahrenheit) and 8 degrees Celsius (45 degrees Fahrenheit)."</p> <p>This state rule applies to federal tag F456.</p>			