

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155797	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2013
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NAME OF PROVIDER OR SUPPLIER  ASPEN PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240
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F000000	<p>This visit was for the Investigation of Complaint IN00132325.</p> <p>Complaint IN00132325 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F279, F282, F333, F425 and F441.</p> <p>Survey dates: July 18, 19 and 22, 2013</p> <p>Facility number: 012854 Provider number: 155797 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 17 SNF/NF: 19 Residential 25 Total: 61</p> <p>Census payor type: Medicare: 12 Medicaid: 19 Other: 30 Total: 61</p> <p>Sample: 5</p> <p>These deficiencies also reflect state</p>	F000000		

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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	findings cited in accordance with 410 IAC 16.2.  Quality review 7/30/13 by Suzanne Williams, RN				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 observation, interview and record review, the facility failed to ensure development of care plans to direct the care and services the facility will provide to 2 of 3 residents reviewed for care plans in the sample of 5. (Resident #A, Resident #B)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 7-18-13 at 11:15 a.m. Her diagnoses included, but were not limited to, left foot wound related to partial amputation, diabetes, renal</p>	F000279	Resident A Care Plans have been updated to reflect her acute renal failure status. Care Plan has been updated to address fluid needs and current skin condition. Dietician consultation with resident in regards to diet choices and following diet as ordered. Resident B has discharged to home. We will audit charts to ensure the development of care plans and services we provide. Care Plans will be reviewed and updated quarterly. DHS will re-educate the interdisciplinary team on the Care Plan process. To ensure care plans are developed and current	08/21/2013	

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	<p>(kidney) failure, diastolic heart failure, high blood pressure, anemia, bipolar disorder, anxiety, and obstructive sleep apnea.</p> <p>Review of Resident #A's care plans indicated, under the category of "Bowel and Bladder," the resident had a history of "ARF," (acute renal/kidney failure). The care plan did not indicate any issues, related to ARF, to monitor for care and services the facility would provide to Resident #A. Documentation in the clinical record indicated 2 previous admissions to an area hospital related to ARF, on 5-9-13 until 5-13-13 and 5-28-13 until 6-14-13.</p> <p>Resident #A's care plan indicated, under the category of "Bowel and Bladder," the resident had a history of dehydration and urinary tract infections. It indicated, "Encourage me to drink adequate and appropriate fluids." Under the category of "Skin," it indicated, "Fluids are encouraged." The care plan did not indicate the physician's orders which specified an 1800 milliliters fluid restriction and was increased to 2000 milliliter on 7-8-13. The resident's Medication Administration Record (MAR) indicated the division of how fluids were to be provided to the resident</p>		<p>we will audit 3 resident charts twice a week for four weeks, then monthly for five months. It will be monitored through QA monthly x's 3 mths. and then randomly thereafter.</p>	

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	<p>throughout the day.</p> <p>Resident #A's care plan indicated, under the category of "Meals/Snacks/Fluids," and dated "5-20-13 to present, "the resident preferred bacon for breakfast. A physician's order on 7-14-13, indicated the resident was not to receive bacon. Documentation by the Dietary Manager on 7-11-13 at 10:50 a.m. indicated a dietary change included a consistent carbohydrate diet with no added salt, no canned soup, no bacon and no lunchmeat. An observation on 7-22-13 at 8:10 a.m. indicated the resident had 2 slices of bacon on her breakfast tray.</p> <p>2. Resident #B's clinical record was reviewed on 7-19-13 at 1:30 p.m. His diagnoses included, but were not limited to, Alzheimer's disease, dementia, anemia, peripheral vascular disease, peripheral arterial disease, high blood pressure, diabetes, anorexia, stage 3 chronic kidney disease, prostate cancer, wound of right foot with MRSA (methicillin resistant staphylococcus aureus) and urine with VRE (vancomycin resistant enterococcus). Due to a decline in condition, the resident was admitted to hospice services on 7-3-13.</p>			

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	<p>Review of Resident #B's care plan indicated, under the category of "Activities of Interest," dated 7-5-13 to present, the resident had encountered a medical decline. Under the category of "Meals/Snacks/Fluids," dated 7-16-13 to present, it indicated the resident was receiving supplements to provide additional protein and nutrition due to wounds. Under the category of "Moods and Behaviors," dated 5-22-13 to present, the care plan indicated the resident was "unable to remember that I have wounds..."</p> <p>The care plan did not include any category of "Skin." The care plan did not indicate any care or services the facility would provide to the resident regarding his skin. The resident was admitted with the heel wound on 4-26-13.</p> <p>The care plan did not indicate the resident's admission to hospice services on 7-3-13. Review of the care plan indicated the MDS (Minimum Data Set assessment) Coordinator did update the resident's care plan on 7-8-13 regarding a fall that was sustained on 7-3-13.</p> <p>In interview with the MDS Coordinator</p>			

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	<p>on 7-19-13 at p.m., she indicated the facility had recently switched to a new format for writing care plans.</p> <p>On 7-22-13 at 11:07 a.m., the MDS Coordinator provided a copy of a policy entitled, "Interdisciplinary Team Care Plan Guideline." This policy was indicated to be the current policy in effect. It indicated the purpose of the policy was, "To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines...Care plan interventions should be reflective of the impact the risk area(s), disease process(es) have on the individual resident...Problems areas should identify the relative concerns. Goals should be measurable and attainable. Interventions should be reflective of the individual's needs and risk influence. Each discipline shall be responsible for a establishing a plan of care of acute problems as they occur...New problem areas should be printed and added to the existing care plans..."</p> <p>This federal tag relates to complaint IN00132325.</p>			

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	3.1-35(a)			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure medications were administered as ordered by the physician for 1 of 3 residents reviewed for medication administration in a sample of 5. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 7-18-13 at 11:15 a.m. Her diagnoses included, but were not limited to, left foot wound related to partial amputation, diabetes, renal (kidney) failure, diastolic heart failure, high blood pressure, anemia, bipolar disorder, anxiety, and obstructive sleep apnea.</p> <p>Review of the "Controlled Drug Record" for Norco (hydrocodone and acetaminophen, a narcotic pain reliever) 5/325 mg (milligrams) indicated the facility received 30 tablets on 5-30-13. The physician orders for this medication indicated from 6-16-13 to 6-26-13 at 2:10 a.m. to administer one tablet every 6 hours</p>	F000282	<p>Reviewed the physician orders, medication administration record, and supply card to ensure they all match for Resident A. Document when holding medication or resident refuses for any reason. Pharmacy to do a Medication Administration Review Audit on all 3 shifts. Medication administration inservicing for staff by DHS or designee. Proper telephone order transcription inservicing by DHS or designee. DHS or Designee to do a medication pass audit weekly for 4 weeks and then monthly for 5 months. It will be monitored through the QA monthly x's 3 mths. and then randomly thereafter.</p>	08/21/2013

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	<p>as needed for pain, by mouth. The orders for this medication changed on 6-26-13 at 2:10 a.m. to indicate to administer one tablet every 4 hours as needed for pain, by mouth. The orders for this medication changed on 6-27-13 at 8:20 a.m. to stop the Norco 5/325 mg and to change to Norco 7.5/325 mg one tablet every 4 hours as needed for pain, by mouth.</p> <p>Review of the "Controlled Drug Record" for the 5/325 mg strength indicated this medication was administered on 6-27-13 at 9:40 p.m. by RN #2 and on 6-28-13 at 1:45 a.m. by LPN #3 and at 1:00 p.m. by LPN #1. These doses of the 5/325 mg were given after this strength had been discontinued and replaced with a higher dosage on 6-27-13.</p> <p>Review of the "Controlled Drug Record" for Norco 7.5/325 mg indicated 18 tablets were received on 6-29-13, time not indicated. The label instructions indicated to administer this medication one tablet every 4 hours as needed for pain, by mouth. The orders for this medication changed on 7-1-13 at 4:09 p.m. via fax to one tablet every 4 hours routinely, by mouth. On 7-6-13, time not indicated, the orders were changed to administer the medication</p>			

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	<p>twice daily, upon rising and at bedtime, by mouth. On 7-7-13, time not indicated, this order was changed to every 4 hours while awake, by mouth. On 7-8-13, this order was changed back to twice daily, upon rising and at bedtime, by mouth. On 7-9-13, the order was changed to one tablet every 4 hours as needed for pain, by mouth.</p> <p>Review of the administration of the Norco 7.5/325 mg via the "Controlled Drug Record," the MAR's (Medication Administration Record) and nursing notes indicated on 7-3-13, no doses were administered at 12:00 a.m., 8:00 a.m. or 12:00 p.m. Documentation did not indicate the reason for not administering the routinely scheduled medication. A notation on the MAR's indicated the resident refused the 4:00 p.m. dose.</p> <p>Record review indicated on 7-4-13, the resident did not receive doses of the Norco 7.5/325 mg at 4:00 p.m. or 8:00 p.m. Documentation did not indicate the reason for not administering the routinely scheduled medication. A notation on the MAR's indicated the resident refused the 4:00 a.m. dose.</p> <p>Review of the "Controlled Drug</p>			

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	<p>Record" for Ativan (an anti-anxiety medication) indicated the facility received 30 tablets of 0.5 mg strength on 5-15-13. The orders indicated on 6-20-13 at 3:03 p.m. via fax, the resident was to receive 0.5 mg every 8 hours as indicated for anxiety, by mouth. Orders were received on 6-27-13 at 8:20 a.m. to change the Ativan to 1 mg every 6 hours routinely, by mouth. Orders were changed on 7-1-13 at 4:09 p.m. by fax to 2 mg every 6 hours routinely, by mouth.</p> <p>Review of the "Controlled Drug Record" for Ativan 0.5 mg indicated on 6-24-13, Resident #A was administered one tablet on 6-24-13 at 11:00 a.m. by LPN #1 and another tablet on 6-24-13 at 2:00 p.m. by LPN #4. This would have been only 3 hours apart between doses, not the ordered 8 hours apart. On 6-27-13 at 6:00 p.m., the resident was administered only 0.5 mg of Ativan, as opposed to the ordered 1 mg of Ativan by RN #2. On 6-28-13 at 12:00 p.m., the resident was administered only 0.5 mg of Ativan, as opposed to the ordered 1 mg of Ativan by LPN #1.</p> <p>Review of the "Controlled Drug Record" for Ativan 2 mg indicated the</p>						

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	<p>facility received 40 tablets on 7-6-13. Documentation on this record indicated the resident received one tablet of the 2 mg strength on 7-7-13 at "6" by RN #3. There was no indication if this dosage was administered at 6:00 a.m. or 6:00 p.m. The dosing was changed on 7-7-13 (no time indicated) to 1.5 mg every 6 hours as needed for anxiety, by mouth. The dosing was again changed on 7-8-13 at 9:00 a.m. to 1.5 mg every 6 hours routinely, by mouth. Documentation on this record indicated one and one-half 2 mg tablets, or 3 mg, were administered on 7-9-13 at 12:00 a.m. from LPN #2. On 7-9-12 at 6:00 a.m., the narcotic log indicated Resident #A received one tablet of the 2 mg Ativan from LPN #2, as opposed to the 1.5 mg that was ordered by the physician.</p> <p>A "Medication Error Circumstance, Assessment and Intervention" document, dated 7-9-13 indicated a medication error occurred on 7-9-13 in which an incorrect dosage of Ativan 3 mg was administered at 12:00 a.m. and at 6:00 a.m. by LPN #2. The correct dose that should have been administered was indicated to be Ativan 1.5 mg every 6 hours, orally. It indicated the attending physician was notified of this event via fax. It</p>			

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	<p>indicated the resident was alert and oriented with no apparent injury. It indicated the medication error was reviewed on 7-9-13 by the Interdisciplinary Team of the facility and LPN #2 was educated on reading the medication label for medication strength and to ensure medications that have been discontinued are destroyed.</p> <p>A "Clinically At Risk" document, dated 7-3-13 indicated the resident recently "has several health issues effecting [sic] physical &amp; mental functioning" which included a fall on 6-29-13 with no apparent injury and "mood/behavior changes" with medication changes ordered by the physician. It indicated the plans were to continue to monitor the resident. A "Change in Condition Form," dated 7-3-13, indicated the resident was "feeling overmedicated and lethargic" with the current dosage of Norco 7.5 mg every 4 hours routine, Ativan 2 mg every 6 hours routine and Trazadone 150 mg at bedtime routinely. The orders were changed by the physician to Norco 7.5 mg routinely upon arising and at bedtime, to Ativan 1.5 mg every 6 hours routinely. The Trazadone was unchanged. The resident's Neurotin was changed to 300 mg at bedtime routinely. On</p>			

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	<p>7-6-13, an additional request was faxed to the attending physician to clarify the Neurotin dose, as the dosage was unchanged, and to request an additional PRN (as needed) dosage for the Norco. The attending physician responded on 7-8-13 to increase the Neurotin 300 mg to twice daily, by mouth and to add Norco 7.5/325 one tablet every 4 hours as needed for pain.</p> <p>Nursing notes from 6-18-13 to 7-12-13 indicated fluctuation of blood sugars from low 100's to over 500, non-compliance with fluid restriction orders, agitation and lethargy.</p> <p>A "Change in Condition Form," dated 5-25-13, indicated the physician was notified on that date of an error in administration of Ferrous Sulfate 325 mg (milligrams). The form indicated the iron supplement had been ordered to be administered twice daily by mouth. The document indicated there had been a transcription error on the MAR and the medication had been administered only once daily from 5-13-13 through 5-24-13. The medication began to be administered twice daily on 5-25-13. The document indicated no apparent injury as a result of the medication error.</p>			

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	<p>Resident #A's laboratory records indicated a CBC (complete blood count) indicated on 4-29-13 her hemoglobin was 10.1 (normal range: 12.0-16.0) and hematocrit was 31.8% (normal range: 37.0%-47.0%). A CBC on 5-13-13 her hemoglobin was 8.4 (normal range: 12.0-15.20) and hematocrit was 26.6% (normal range: 37.0%-46.0%). A CBC on 6-28-13 indicated her hemoglobin was 8.0 and hematocrit was 24.6%. The attending physician indicated, "CBC - HGb [hemoglobin] is (low) but stable," and requested a repeat of the CBC in 2 weeks. The CBC results dated 7-8-13, indicated the hemoglobin had risen to 8.7 and the hematocrit to 27.0%.</p> <p>In interview with RN #1 on 7-18-13 at 1:55 p.m. she indicated the resident has a complicated medical history, "when she begins to get into problems, there seems to be little, if any warning, and is very ill quickly."</p> <p>In interview with the MDS (Minimum Data Set assessment) Coordinator on 7-18-13 at 1:55 p.m., she indicated an error had occurred with the Ativan in which the dosage had been changed by the attending physician. She indicated the previous dose was</p>			

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	<p>still in the medication cart and the new and correct dose had not arrived from the pharmacy yet. She indicated the staff person apparently read the label of the medication incorrectly and administered the previous/incorrect dosage to Resident #A and the resident received too large of a dose of the Ativan. The MDS coordinator was referring to a medication error on 7-9-13.</p> <p>On 7-19-13 at 12:05 p.m., the Director of Health Services (DHS) provided a copy of a policy entitled, "Medication Administration-General Guidelines." This was indicated to be the current policy in effect. This policy indicated, "...Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are administered in accordance with written orders of the attending physician...If a dose of a regularly scheduled medication is withheld,</p>						

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	<p>refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed medications, not routine medications] documentation. If one dose of a vital medication are [sic] withheld or refused, the physician is notified."</p> <p>On 7-22-13 at 10:40 a.m., the DHS provided a copy of a policy entitled, "Guidelines for Telephone Orders." This was indicated to be the current policy in effect. This policy indicated, "Purpose: To provide guidelines for the obtainment and documentation of physician telephone orders...The entry shall contain the instructions from the physician, time, date, and signature and title of the person transcribing the information. Medication orders shall contain the name of the medication, dose, diagnosis for use, route to be administered and stop date, if applicable..."</p> <p>This federal tag relates to complaint IN00132325.</p>			

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	3.1-35(g)(2)			

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure significant medications errors did not occur for 1 of 3 residents reviewed for medication administration in a sample of 5. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 7-18-13 at 11:15 a.m. Her diagnoses included, but were not limited to, left foot wound related to partial amputation, diabetes, renal (kidney) failure, diastolic heart failure, high blood pressure, anemia, bipolar disorder, anxiety, and obstructive sleep apnea.</p> <p>Review of the "Controlled Drug Record" for Norco (hydrocodone and acetaminophen, a narcotic pain reliever) 5/325 mg (milligrams) indicated the facility received 30 tablets on 5-30-13. The physician orders for this medication indicated from 6-16-13 to 6-26-13 at 2:10 a.m. to administer one tablet every 6 hours as needed for pain, by mouth. The orders for this medication changed on 6-26-13 at 2:10 a.m. to indicate to</p>	F000333	<p>Reviewed the physician orders, medication administration record, and supply card to ensure they all match for Resident A. Pharmacy to do a Medication Administration Review Audit on all 3 shifts. Medication administration inservicing for staff by DHS or designee. Proper telephone order transcription inservicing by DHS or designee. DHS or Designee to do a medication pass audit weekly for 4 weeks and then monthly for 5 months. It will be monitored through the QA monthly x's 3 ths. and then randomly thereafter.</p>	08/21/2013			

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	<p>administer one tablet every 4 hours as needed for pain, by mouth. The orders for this medication changed on 6-27-13 at 8:20 a.m. to stop the Norco 5/325 mg and to change to Norco 7.5/325 mg one tablet every 4 hours as needed for pain, by mouth.</p> <p>Review of the "Controlled Drug Record" for the 5/325 mg strength indicated this medication was administered on 6-27-13 at 9:40 p.m. by RN #2 and on 6-28-13 at 1:45 a.m. by LPN #3 and at 1:00 p.m. by LPN #1. These doses of the 5/325 mg were given after this strength had been discontinued and replaced with a higher dosage on 6-27-13.</p> <p>Review of the "Controlled Drug Record" for Norco 7.5/325 mg indicated 18 tablets were received on 6-29-13, time not indicated. The label instructions indicated to administer this medication one tablet every 4 hours as needed for pain, by mouth. The orders for this medication changed on 7-1-13 at 4:09 p.m. via fax to one tablet every 4 hours routinely, by mouth. On 7-6-13, time not indicated, the orders were changed to administer the medication twice daily, upon rising and at bedtime, by mouth. On 7-7-13, time not indicated, this order was changed</p>						

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	<p>to every 4 hours while awake, by mouth. On 7-8-13, this order was changed back to twice daily, upon rising and at bedtime, by mouth. On 7-9-13, the order was changed to one tablet every 4 hours as needed for pain, by mouth.</p> <p>Review of the administration of the Norco 7.5/325 mg via the "Controlled Drug Record," the MAR's (Medication Administration Record) and nursing notes indicated on 7-3-13, no doses were administered at 12:00 a.m., 8:00 a.m. or 12:00 p.m. Documentation did not indicate the reason for not administering the routinely scheduled medication. A notation on the MAR's indicated the resident refused the 4:00 p.m. dose.</p> <p>Record review indicated on 7-4-13, the resident did not receive doses of the Norco 7.5/325 mg at 4:00 p.m. or 8:00 p.m. Documentation did not indicate the reason for not administering the routinely scheduled medication. A notation on the MAR's indicated the resident refused the 4:00 a.m. dose.</p> <p>Review of the "Controlled Drug Record" for Ativan (an anti-anxiety medication) indicated the facility received 30 tablets of 0.5 mg strength</p>			

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	<p>on 5-15-13. The orders indicated on 6-20-13 at 3:03 p.m. via fax, the resident was to receive 0.5 mg every 8 hours as indicated for anxiety, by mouth. Orders were received on 6-27-13 at 8:20 a.m. to change the Ativan to 1 mg every 6 hours routinely, by mouth. Orders were changed on 7-1-13 at 4:09 p.m. by fax to 2 mg every 6 hours routinely, by mouth.</p> <p>Review of the "Controlled Drug Record" for Ativan 0.5 mg indicated on 6-24-13, Resident #A was administered one tablet on 6-24-13 at 11:00 a.m. by LPN #1 and another tablet on 6-24-13 at 2:00 p.m. by LPN #4. This would have been only 3 hours apart between doses, not the ordered 8 hours apart. On 6-27-13 at 6:00 p.m., the resident was administered only 0.5 mg of Ativan, as opposed to the ordered 1 mg of Ativan by RN #2. On 6-28-13 at 12:00 p.m., the resident was administered only 0.5 mg of Ativan, as opposed to the ordered 1 mg of Ativan by LPN #1.</p> <p>Review of the "Controlled Drug Record" for Ativan 2 mg indicated the facility received 40 tablets on 7-6-13. Documentation on this record indicated the resident received one</p>			

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	<p>tablet of the 2 mg strength on 7-7-13 at "6" by RN #3. There was no indication if this dosage was administered at 6:00 a.m. or 6:00 p.m. The dosing was changed on 7-7-13 (no time indicated) to 1.5 mg every 6 hours as needed for anxiety, by mouth. The dosing was again changed on 7-8-13 at 9:00 a.m. to 1.5 mg every 6 hours routinely, by mouth. Documentation on this record indicated one and one-half 2 mg tablets, or 3 mg, were administered on 7-9-13 at 12:00 a.m. from LPN #2. On 7-9-12 at 6:00 a.m., the narcotic log indicated Resident #A received one tablet of the 2 mg Ativan from LPN #2, as opposed to the 1.5 mg that was ordered by the physician.</p> <p>A "Medication Error Circumstance, Assessment and Intervention" document, dated 7-9-13 indicated a medication error occurred on 7-9-13 in which an incorrect dosage of Ativan 3 mg was administered at 12:00 a.m. and at 6:00 a.m. by LPN #2. The correct dose that should have been administered was indicated to be Ativan 1.5 mg every 6 hours, orally. It indicated the attending physician was notified of this event via fax. It indicated the resident was alert and oriented with no apparent injury. It indicated the medication error was</p>						

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	<p>reviewed on 7-9-13 by the Interdisciplinary Team of the facility and LPN #2 was educated on reading the medication label for medication strength and to ensure medications that have been discontinued are destroyed.</p> <p>A "Clinically At Risk" document, dated 7-3-13 indicated the resident recently "has several health issues effecting [sic] physical &amp; mental functioning" which included a fall on 6-29-13 with no apparent injury and "mood/behavior changes" with medication changes ordered by the physician. It indicated the plans were to continue to monitor the resident. A "Change in Condition Form," dated 7-3-13, indicated the resident was "feeling overmedicated and lethargic" with the current dosage of Norco 7.5 mg every 4 hours routine, Ativan 2 mg every 6 hours routine and Trazadone 150 mg at bedtime routinely. The orders were changed by the physician to Norco 7.5 mg routinely upon arising and at bedtime, to Ativan 1.5 mg every 6 hours routinely. The Trazadone was unchanged. The resident's Neurotin was changed to 300 mg at bedtime routinely. On 7-6-13, an additional request was faxed to the attending physician to clarify the Neurotin dose, as the</p>						

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	<p>dosage was unchanged, and to request an additional PRN (as needed) dosage for the Norco. The attending physician responded on 7-8-13 to increase the Neurotin 300 mg to twice daily, by mouth and to add Norco 7.5/325 one tablet every 4 hours as needed for pain.</p> <p>Nursing notes from 6-18-13 to 7-12-13 indicated fluctuation of blood sugars from low 100's to over 500, non-compliance with fluid restriction orders, agitation and lethargy.</p> <p>A "Change in Condition Form," dated 5-25-13, indicated the physician was notified on that date of an error in administration of Ferrous Sulfate 325 mg (milligrams). The form indicated the iron supplement had been ordered to be administered twice daily by mouth. The document indicated there had been a transcription error on the MAR and the medication had been administered only once daily from 5-13-13 through 5-24-13. The medication began to be administered twice daily on 5-25-13. The document indicated no apparent injury as a result of the medication error.</p> <p>Resident #A's laboratory records indicated a CBC (complete blood</p>			

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	<p>count) indicated on 4-29-13 her hemoglobin was 10.1 (normal range: 12.0-16.0) and hematocrit was 31.8% (normal range: 37.0%-47.0%). A CBC on 5-13-13 her hemoglobin was 8.4 (normal range: 12.0-15.20) and hematocrit was 26.6% (normal range: 37.0%-46.0%). A CBC on 6-28-13 indicated her hemoglobin was 8.0 and hematocrit was 24.6%. The attending physician indicated, "CBC - HGb [hemoglobin] is (low) but stable," and requested a repeat of the CBC in 2 weeks. The CBC results dated 7-8-13, indicated the hemoglobin had risen to 8.7 and the hematocrit to 27.0%.</p> <p>In interview with RN #1 on 7-18-13 at 1:55 p.m. she indicated the resident has a complicated medical history, "when she begins to get into problems, there seems to be little, if any warning, and is very ill quickly."</p> <p>In interview with the MDS (Minimum Data Set assessment) Coordinator on 7-18-13 at 1:55 p.m., she indicated an error had occurred with the Ativan in which the dosage had been changed by the attending physician. She indicated the previous dose was still in the medication cart and the new and correct dose had not arrived from the pharmacy yet. She indicated</p>			

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	<p>the staff person apparently read the label of the medication incorrectly and administered the previous/incorrect dosage to Resident #A and the resident received too large of a dose of the Ativan. The MDS coordinator was referring to a medication error on 7-9-13.</p> <p>On 7-19-13 at 12:05 p.m., the Director of Health Services (DHS) provided a copy of a policy entitled, "Medication Administration-General Guidelines." This was indicated to be the current policy in effect. This policy indicated, "...Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are administered in accordance with written orders of the attending physician...If a dose of a regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose</p>			

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	<p>time, or starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed medications, not routine medications] documentation. If one dose of a vital medication are [sic] withheld or refused, the physician is notified."</p> <p>This federal tag relates to complaint IN00132325.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>			

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F000425 SS=D	<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. Based on observation, interview and record review, the facility failed to ensure the administration of physician ordered medications were conducted as ordered and failed to ensure medication orders received from the physician were correct, for 2 of 3 residents reviewed for medication administration in a sample of 5. (Resident #A, Resident #C)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 7-18-13 at 11:15 a.m. Her diagnoses included, but were not</p>	F000425	Reviewed the physician orders, medication administration record, and medication supplied from pharmacy match for resident A. Resident C has discharged to home.DHS or designee will provide inservicing to staff regarding accurate physician order transcription.DHS or designee will audit physician orders for accuracy on all residents.Physician orders will be reviewed for accuracy during the clinical care meeting five times a week for accuracy and monthly during month end change over by DHS or designee.It will be monitored through the QA monthly x's 6 mths. and then	08/21/2013	

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	<p>limited to, left foot wound related to partial amputation, diabetes, renal (kidney) failure, diastolic heart failure, high blood pressure, anemia, bipolar disorder, anxiety, and obstructive sleep apnea.</p> <p>Review of the "Controlled Drug Record" for Norco (hydrocodone and acetaminophen, a narcotic pain reliever) 5/325 mg (milligrams) indicated the facility received 30 tablets on 5-30-13. The physician orders for this medication indicated from 6-16-13 to 6-26-13 at 2:10 a.m. to administer one tablet every 6 hours as needed for pain, by mouth. The orders for this medication changed on 6-26-13 at 2:10 a.m. to indicate to administer one tablet every 4 hours as needed for pain, by mouth. The orders for this medication changed on 6-27-13 at 8:20 a.m. to stop the Norco 5/325 mg and to change to Norco 7.5/325 mg one tablet every 4 hours as needed for pain, by mouth.</p> <p>Review of the "Controlled Drug Record" for the 5/325 mg strength indicated this medication was administered on 6-27-13 at 9:40 p.m. by RN #2 and on 6-28-13 at 1:45 a.m. by LPN #3 and at 1:00 p.m. by LPN #1. These doses of the 5/325 mg were given after this strength had</p>		randomly thereafter to ensure deficient practice does not reoccur.				

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	<p>been discontinued and replaced with a higher dosage on 6-27-13.</p> <p>Review of the "Controlled Drug Record" for Norco 7.5/325 mg indicated 18 tablets were received on 6-29-13, time not indicated. The label instructions indicated to administer this medication one tablet every 4 hours as needed for pain, by mouth. The orders for this medication changed on 7-1-13 at 4:09 p.m. via fax to one tablet every 4 hours routinely, by mouth. On 7-6-13, time not indicated, the orders were changed to administer the medication twice daily, upon rising and at bedtime, by mouth. On 7-7-13, time not indicated, this order was changed to every 4 hours while awake, by mouth. On 7-8-13, this order was changed back to twice daily, upon rising and at bedtime, by mouth. On 7-9-13, the order was changed to one tablet every 4 hours as needed for pain, by mouth.</p> <p>Review of the administration of the Norco 7.5/325 mg via the "Controlled Drug Record," the MAR's (Medication Administration Record) and nursing notes indicated on 7-3-13, no doses were administered at 12:00 a.m., 8:00 a.m. or 12:00 p.m. Documentation did not indicate the reason for not</p>			

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	<p>administering the routinely scheduled medication. A notation on the MAR's indicated the resident refused the 4:00 p.m. dose.</p> <p>Record review indicated on 7-4-13, the resident did not receive doses of the Norco 7.5/325 mg at 4:00 p.m. or 8:00 p.m. Documentation did not indicate the reason for not administering the routinely scheduled medication. A notation on the MAR's indicated the resident refused the 4:00 a.m. dose.</p> <p>Review of the "Controlled Drug Record" for Ativan (an anti-anxiety medication) indicated the facility received 30 tablets of 0.5 mg strength on 5-15-13. The orders indicated on 6-20-13 at 3:03 p.m. via fax, the resident was to receive 0.5 mg every 8 hours as indicated for anxiety, by mouth. Orders were received on 6-27-13 at 8:20 a.m. to change the Ativan to 1 mg every 6 hours routinely, by mouth. Orders were changed on 7-1-13 at 4:09 p.m. by fax to 2 mg every 6 hours routinely, by mouth.</p> <p>Review of the "Controlled Drug Record" for Ativan 0.5 mg indicated on 6-24-13, Resident #A was administered one tablet on 6-24-13 at</p>			

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	<p>11:00 a.m. by LPN #1 and another tablet on 6-24-13 at 2:00 p.m. by LPN #4. This would have been only 3 hours apart between doses, not the ordered 8 hours apart. On 6-27-13 at 6:00 p.m., the resident was administered only 0.5 mg of Ativan, as opposed to the ordered 1 mg of Ativan by RN #2. On 6-28-13 at 12:00 p.m., the resident was administered only 0.5 mg of Ativan, as opposed to the ordered 1 mg of Ativan by LPN #1.</p> <p>Review of the "Controlled Drug Record" for Ativan 2 mg indicated the facility received 40 tablets on 7-6-13. Documentation on this record indicated the resident received one tablet of the 2 mg strength on 7-7-13 at "6" by RN #3. There was no indication if this dosage was administered at 6:00 a.m. or 6:00 p.m. The dosing was changed on 7-7-13 (no time indicated) to 1.5 mg every 6 hours as needed for anxiety, by mouth. The dosing was again changed on 7-8-13 at 9:00 a.m. to 1.5 mg every 6 hours routinely, by mouth. Documentation on this record indicated one and one-half 2 mg tablets, or 3 mg, were administered on 7-9-13 at 12:00 a.m. from LPN #2. On 7-9-12 at 6:00 a.m., the narcotic log indicated Resident #A received</p>			

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	<p>one tablet of the 2 mg Ativan from LPN #2, as opposed to the 1.5 mg that was ordered by the physician.</p> <p>A "Medication Error Circumstance, Assessment and Intervention" document, dated 7-9-13 indicated a medication error occurred on 7-9-13 in which an incorrect dosage of Ativan 3 mg was administered at 12:00 a.m. and at 6:00 a.m. by LPN #2. The correct dose that should have been administered was indicated to be Ativan 1.5 mg every 6 hours, orally. It indicated the attending physician was notified of this event via fax. It indicated the resident was alert and oriented with no apparent injury. It indicated the medication error was reviewed on 7-9-13 by the Interdisciplinary Team of the facility and LPN #2 was educated on reading the medication label for medication strength and to ensure medications that have been discontinued are destroyed.</p> <p>A "Clinically At Risk" document, dated 7-3-13 indicated the resident recently "has several health issues effecting [sic] physical &amp; mental functioning" which included a fall on 6-29-13 with no apparent injury and "mood/behavior changes" with medication changes ordered by the</p>			

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	<p>physician. It indicated the plans were to continue to monitor the resident. A "Change in Condition Form," dated 7-3-13, indicated the resident was "feeling overmedicated and lethargic" with the current dosage of Norco 7.5 mg every 4 hours routine, Ativan 2 mg every 6 hours routine and Trazadone 150 mg at bedtime routinely. The orders were changed by the physician to Norco 7.5 mg routinely upon arising and at bedtime, to Ativan 1.5 mg every 6 hours routinely. The Trazadone was unchanged. The resident's Neurotin was changed to 300 mg at bedtime routinely. On 7-6-13, an additional request was faxed to the attending physician to clarify the Neurotin dose, as the dosage was unchanged, and to request an additional PRN (as needed) dosage for the Norco. The attending physician responded on 7-8-13 to increase the Neurotin 300 mg to twice daily, by mouth and to add Norco 7.5/325 one tablet every 4 hours as needed for pain.</p> <p>Nursing notes from 6-18-13 to 7-12-13 indicated fluctuation of blood sugars from low 100's to over 500, non-compliance with fluid restriction orders, agitation and lethargy.</p> <p>A "Change in Condition Form," dated</p>			

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	<p>5-25-13, indicated the physician was notified on that date of an error in administration of Ferrous Sulfate 325 mg (milligrams). The form indicated the iron supplement had been ordered to be administered twice daily by mouth. The document indicated there had been a transcription error on the MAR and the medication had been administered only once daily from 5-13-13 through 5-24-13. The medication began to be administered twice daily on 5-25-13. The document indicated no apparent injury as a result of the medication error.</p> <p>Resident #A's laboratory records indicated a CBC (complete blood count) indicated on 4-29-13 her hemoglobin was 10.1 (normal range: 12.0-16.0) and hematocrit was 31.8% (normal range: 37.0%-47.0%). A CBC on 5-13-13 her hemoglobin was 8.4 (normal range: 12.0-15.20) and hematocrit was 26.6% (normal range: 37.0%-46.0%). A CBC on 6-28-13 indicated her hemoglobin was 8.0 and hematocrit was 24.6%. The attending physician indicated, "CBC - HGb [hemoglobin] is (low) but stable," and requested a repeat of the CBC in 2 weeks. The CBC results dated 7-8-13, indicated the hemoglobin had risen to 8.7 and the hematocrit to</p>						

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	<p>27.0%.</p> <p>In interview with RN #1 on 7-18-13 at 1:55 p.m. she indicated the resident has a complicated medical history, "when she begins to get into problems, there seems to be little, if any warning, and is very ill quickly."</p> <p>In interview with the MDS (Minimum Data Set assessment) Coordinator on 7-18-13 at 1:55 p.m., she indicated an error had occurred with the Ativan in which the dosage had been changed by the attending physician. She indicated the previous dose was still in the medication cart and the new and correct dose had not arrived from the pharmacy yet. She indicated the staff person apparently read the label of the medication incorrectly and administered the previous/incorrect dosage to Resident #A and the resident received too large of a dose of the Ativan. The MDS coordinator was referring to a medication error on 7-9-13.</p> <p>2. Resident #C's clinical record was reviewed on 7-22-13 at 7:10 a.m. Her diagnoses included, but were not limited to, left knee replacement July, 2013, diabetes, osteoarthritis.</p> <p>Review of the resident's admission</p>			

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	<p>physician orders, dated 7-12-13, indicated, "Sliding scale insulin AC/HS [before meals and at bedtime]." The physician order then specified how much insulin to administer, based upon the blood glucose reading prior to each meal or at bedtime. A clarification request was faxed to the physician on 7-12-13, time not indicated, by RN #2 to ensure accuracy of the physician's order. Another clarification, dated 7-13-13 with no time indicated, was forwarded to the physician by LPN #5. None of these orders specified what type of insulin was to be administered for the sliding scale insulin. The MAR did specify to administer Humalog insulin.</p> <p>In interview with LPN #6 on 7-22-13 at 7:25 a.m., she indicated she thought the insulin for the sliding scale was Humalog insulin. Observation of the medication cart at this time indicated a Kwikpen of Humalog insulin and labeled for the use of Resident #C was present with the sliding scale orders listed.</p> <p>On 7-19-13 at 12:05 p.m., the Director of Health Services (DHS) provided a copy of a policy entitled, "Medication Administration-General Guidelines." This was indicated to be</p>			

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	<p>the current policy in effect. This policy indicated, "...Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are administered in accordance with written orders of the attending physician...If a dose of a regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed medications, not routine medications] documentation. If one dose of a vital medication are [sic] withheld or refused, the physician is notified."</p> <p>On 7-22-13 at 10:40 a.m., the DHS provided a copy of a policy entitled,</p>			

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	<p>"Guidelines for Telephone Orders." This was indicated to be the current policy in effect. This policy indicated, "Purpose: To provide guidelines for the obtainment and documentation of physician telephone orders...The entry shall contain the instructions from the physician, time, date, and signature and title of the person transcribing the information. Medication orders shall contain the name of the medication, dose, diagnosis for use, route to be administered and stop date, if applicable..."</p> <p>This federal tag relates to complaint IN00132325.</p> <p>3.1-25(a) 3.1-25(b) 3.1-25(b)(9)</p>			

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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	Resident D discharged to home. Resident E shows no signs	08/21/2013			

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	<p>ensure appropriate hand hygiene was performed prior to the administration of eye drops for 2 of 2 residents observed receiving eye drops and touched a resident's medication with bare hands prior to administering the medications. (Resident #D, Resident #E, RN #1, LPN #1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During a medication pass observation on 7-18-13 at 11:08 a.m. with RN #1, she was observed to perform handwashing and don gloves prior to performing a blood glucose test on Resident #D. She was then observed to change gloves without performing handwashing or hand hygiene. She was then observed to administer one eye drop of Artificial Tears into the resident's left eye. In interview with RN #1 on 7-18-13 at 11:11 a.m., she indicated she did not wash her hands between performing the blood glucose test and administering the eye drop. She indicated, "I did change my gloves between the glucometer [machine used to test the blood glucose] and the eye drops."</li> <li>2. During a medication pass observation on 7-19-13 at 8:40 a.m. with LPN #1, she was observed to</li> </ol>		<p>or symptoms of eye infection.Immediate one on one staff education was provided to the staff members involved in the infection control breach.DHS or designee will educate nursing staff on eye drop administration.DHS or designee will educate nursing staff on handwashing.Random eye drop observation once a week for four weeks, then monthly for five months.Residents will be monitored for eye infection and appropriate intervention implemented.It will be monitored through QA monthly x 3 months. then randomly thereafter.</p>		

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	<p>perform hand hygiene with hand sanitizer prior to preparing Resident #E's medications. She was observed to count the quantity of pills and capsules by pouring them onto a paper cloth, then pushing them back into the pill cup with a bare finger. Upon entering Resident #E's room and prior to obtaining the resident's blood pressure and pulse and then administering the oral medications, LPN #1 was observed to perform hand hygiene with hand sanitizer. Upon completion of administering the oral medications, LPN #1 was observed to don gloves without performing hand hygiene. She was then observed to administer 3 drops of Gentamic Ophthalmic Solution into the resident's left eye. In interview with LPN #1 on 7-19-13 at 8:44 a.m., she indicated she should have washed her hands before putting on the gloves and administering the eye drops.</p> <p>On 7-19-13 at 12:05 p.m., the Director of Health Services (DHS) provided a policy entitled, "Guidelines for Handwashing." This policy was indicated to be the current policy in effect. This policy indicated, "Handwashing is the single most important factor in preventing the transmission of infections...Health</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155797	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2013
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	<p>Care Workers shall wash hands at times such as...before/after having direct contact with residents...Waterless hand cleaning products such as alcohol based gels...do not use them immediately before performing eye care because of danger of eye irritation."</p> <p>On 7-19-13 at 12:05 p.m., the DHS provided a copy of a policy entitled, "Medication Administration-General Guidelines." This was indicated to be the current policy in effect. This policy indicated, "...Hands are washed before and after administration of ...ophthalmic...medications. Gloves should be worn when administering these medications..."</p> <p>This federal tag relates to complaint IN00132325.</p> <p>3.1-18(b) 3.1-18(l)</p>			