

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155352	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2013
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NAME OF PROVIDER OR SUPPLIER ELKHART REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00123548.</p> <p>Survey Dates: February 4, 5, 6, 7, and 8, 2013</p> <p>Facility Number: 000243 Provider: 155352 AIM Number: 100289830</p> <p>Survey Team: Debora Kammeyer, RN-TC (2/4, 2/5, 2/6, 2/7, 2/8, 2013) Amber Bloss, Medical Surveyor (2/6, 2/7, 2013) Shauna Carson, RN (2/5, 2/6, 2/7, 2/8, 2013) Shelly Miller-Vice, RN (2/4) Lora Swanson, RN (2/4, 2/5, 2/6, 2/7, 2/8, 2013)</p> <p>Census Bed Type: SNF/NF: 52 Total : 52</p> <p>Census Payor Type: Medicare: 3 Medicaid: 46</p>	F0000		

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

TITLE

(X6) DATE

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

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	<p>Other: 3 Total: 52</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 2/18/13, by Brenda Meredith, R.N.</p>				

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on observation, interview and record review, the facility failed to act on the grievance of a resident randomly interviewed for grievance. Resident #43</p> <p>Finding includes:</p> <p>During an interview on 2-5-13 at 4:10 p.m., Resident #43 indicated that he would prefer milk rather than water between his meals and with the evening snack. The resident stated, "I have told everyone that I want milk."</p> <p>A medical chart review on 2-5-13 at 4:30 p.m., indicated the resident was on a no added salt regular diet. There were no milk restrictions noted.</p> <p>During an interview on 2-7-13 at 1:45 p.m., Activity Director (AD) #5 indicated the resident's had complained to her about not getting milk with the evening snack. She doesn't recall who made the decision to stop serving milk with the evening snack but that it had..."upset the</p>	F0166	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report.F-166 483.10(F) (2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES. The facility will make every effort to resolve grievances that residents may have including those with respect to the behavior of other residents. Resident #34 will be offered milk with his evening snack as evidenced by staff completing a PM Snack Audit Sheet where they will record that residents have been offered their evening snacks and beverages. Specific areas of concern from each Resident Council Meeting will be treated as a grievance and dealt with per facility grievance policy. The resolution to each concern will be communicated back to the Resident Council at a follow up Council meeting to be scheduled within one week of the original concern, but totally at the</p>	03/08/2013			

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	<p>residents."</p> <p>During the environment tour, on 2-7-13 at 10:33 a.m. and 2:00 p.m., accompanied by Employee #13, the snack refrigerator did not have milk in it.</p> <p>On 2-7-13 at 2:15 p.m., an interview was conducted with Administrator #6 and the Dietary Manager. The Dietary Manager explained that milk was offered every evening and indicated one gallon of milk would be in the refrigerator for this evenings snack time. It was brought to her attention that no milk was in the refrigerator this morning or this afternoon. The meeting ended with the Administrator #7 indicating that milk would be stocked in the snack refrigerator and that residents would be offered milk with their evening snack</p> <p>During an interview on 2-8-13 at 10:08 a.m., Resident #43 that indicated he was not offered milk or any other beverage with his evening snack last night.</p> <p>During an interview on 2-8-13 at 10:20 a.m., the Director of Nursing (DON) indicated the CNA's (Certified Nursing Assistants) were instructed to</p>		<p>discression of the Resident Council Officers. All residents have the potential to be effected by this deficient practice. Facility Staff have been re-educated on the passing of evening snacks and on how to properly complete the PM Snack Audit Sheet. All PM Snack Audit Sheets will be reviewed by the facility DON, or designee, on a weekly basis for a period of 30 days, then bi-weekly for an additional 30 day period, and then monthly thereafter. All audit results will be reviewed at the facility Monthly QPI Meetings. Any negative findings will be immediately addressed by the facility Administrator or designee. All residents have the potential to be effected by this deficient practice. Residents residing in facility will have their concerns addressed by following the Grievance policy and procedure, re-education and/or disciplinary action of employees per facility policy. Completion Date: 3-8-13</p>				

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	<p>pass the juices and milk last night. She had done a verbal audit with the residents this morning and had realized the liquids were not offered.</p> <p>3.1-7(a)(2)</p>			

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F0226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F0226	F-226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES. The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. All residents have the potential to be affected by this deficient practice. Residents residing in facility will have their concerns addressed by following the Grievance policy and procedure, re-education and/or disciplinary action of employees per facility policy. All facility staff have been re-in serviced on the Abuse Policy and the types of abuse by the facility Staff Development Coordinator or designee. Each employee will continue to review the facility Abuse Policy and Procedure at the time of their New Employee Orientation and at least annually thereafter. Each employee will receive a sticker listing the tyopes	03/08/2013	

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	1. Based on record review and interview, the facility failed to follow their policy related to abuse training by failing to thoroughly train 6 of 8 employees (CNA #9 , CNA #10, CNA #11, CNA #14, RN #12, RN #15) interviewed on what constitutes abuse, neglect, and mistreatment which had the potential to effect 52 of 52 residents.		of Abuse to be worn on their name badge for quick reference and as a required part of their uniform. The facility Abuse Policy & Procedure and Types of Abuse will be reviewed at the Monthly All Staff Meetings for a period of 120 days by the Staff Development Coordinator, or designee. The facility Administrator/DON or designee will monitor for compliance as part of their daily facility rounding activities. Any staff found to be in violation will be required to immediately acquire another sticker from the facility DON or designee. All in-serfvice results will be reviewed at the facility Monthly QPI Meetings for the next three months. Any negative findings will be immediately addressed by the facility Administrator. Completion Date: 3-8-13				

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	<p>2. Based on interview and record review, the facility failed to follow their policy to screen all potential employees for a history of abuse, neglect, or mistreatment of residents during the hiring process by failing to provide documentation of reference checks for 1 of 10 employee's reviewed which had the potential to effect 52 of 52 residents in the facility.</p> <p>Findings include:</p> <p>1. On 2-6-2013 beginning at 10:55 AM, interviews with a sample selection of employees indicated a lack of thorough knowledge of what constitutes abuse and neglect for 6 of 8 employees (CNA #9 , CNA #10, CNA #11, CNA #14, RN #12, RN #15) as evidenced by the following:</p> <p>Employee #12 was unable to identify verbal abuse or involuntary seclusion as part of the seven elements that constitute abuse and neglect.</p> <p>Employee #9 was not able to identify involuntary seclusion, verbal abuse, sexual abuse, nor misappropriation of funds as elements of abuse.</p> <p>Employee # 10 was unable to identify involuntary seclusion and</p>			

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	<p>misappropriation of funds as forms of abuse.</p> <p>Employee # 11 was unable to independently identify sexual abuse, physical abuse, verbal abuse, and involuntary seclusion. Employee #11 was also unaware of outside agencies that could be contacted to report abuse and was unaware of the Elder Justice Act.</p> <p>Employee #15 was unable to identify involuntary confinement as a form of abuse.</p> <p>On 2-6-2013 at 11:15 AM, the facility policy on abuse (Clinical Administrative Manual effective 10-1999, revised 2-2011, 4-2012) was received from Administrator #7 as current. The facility policy on abuse (1.1.2-1.1.3 Section A) identifies verbal abuse, physical abuse, sexual abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property as elements of abuse and neglect. The facility policy on abuse training (1.14 Section A) indicated the facility would "provide training for new employees through orientation and with ongoing training programs..." and will include training on the "definitions of abuse, neglect, mistreatment,</p>			

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	<p>injuries of unknown source, and misappropriation of property."</p> <p>On 2/07/13 at 10:02 AM, the DON was interviewed and indicated all employees are trained on abuse and neglect during new hire orientation.</p> <p>No further documentation was provided to indicate ongoing abuse and neglect training.</p> <p>2. On 2-6-2013 at 11:15 AM, the facility policy on abuse (Clinical Administrative Manual effective 10-1999, revised 2-2011, 4-2012) was received from Administrator #7 as current. The facility policy on the procedure for screening all potential employees for a history of abuse, neglect, or mistreatment of residents during the hiring process (1.1.3 Section A) indicated screening would include "reference checks from previous and/or current employers".</p> <p>On 2-7-2013 at 8:30 AM, a sample of 10 employee records were reviewed which indicated the facility lacked documentation of Employee #8's references being checked prior to employment.</p> <p>On 2-7-2013 at 10:15 AM, the Dietary Manager was interviewed and</p>				

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	<p>indicated she only checked one reference for Employee #8 prior to her employment with the facility. The Dietary Manager provided documentation of the one reference check for Employee #8 which lacked any specific work history or positive job reference. The Dietary Manager indicated she was aware two references checks were required.</p> <p>3.1-28(a)</p>			

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F0244 SS=D	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on record review and interview, the facility failed to listen to the views of the Resident Council and act upon the grievances and recommendations of residents concerning fluids being offered at night snack. This concern relates to 2 of 7 residents attending the Resident Council meetings. (Resident #36 and Resident #43)</p> <p>Findings include:</p> <p>1. On 2/6/13 at 2:35 p.m., the Resident Council President #36 was interviewed and indicated many residents were unhappy with the facilities decision to discontinue offering milk with the night snack. Resident # 36 indicated the resident counsel was unaware why the facility discontinued offering milk. The resident indicated the resident counsel brought their grievance to the Activity Director during a meeting to give to the administration but had not received a response thus far.</p>	F0244	<p>F-244 483.15© (6) LISTENING/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>The facility will listen to the views of the Resident Council and act upon the grievances and recommendations of the residents.</p> <p>Resident #36 and resident #43 were found to have had no negative effects by this deficient practice. Resident's Care Plans were reviewed and updated as needed to reflect current status. All residents have the potential to be effected by this deficient practice. Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.</p> <p>Residents' #36 and #43 will be offered milk with their evening snacks as evidenced by staff completion of a PM Snack Audit Sheet where staff will record that residents were offered their evening snacks and beverages</p>	03/08/2013	

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	<p>On 2/7/13 at 1:05 p.m., Resident Council meeting minutes were reviewed from 5/2/12 to 1/22/13 which indicated the Resident Council had voiced a grievance regarding the discontinuation of milk at night snack at the 12/7/12 meeting. The administrator signature was not on the meeting's minutes.</p> <p>On 2/7/13 at 12:56 p.m., the Activity Director was interviewed and indicated she did not have documentation the administration had given the residents a response to their grievance regarding milk at snack time.</p> <p>On 2/7/12 at 2:15 p.m., Administrator #6 and Administrator #7 were interviewed. Administrator #6 indicated their administration usually responded to Resident Council grievances which would then be reviewed with the residents at the next monthly meeting.</p> <p>Record review of the policy titled Resident Council revised January 2010, on 2-8-13 at 9:00 a.m., indicated, "...The center Administrator and/or Director of Nursing will listen to the views and accommodate the recommendations of the Resident</p>		<p>which shall include milk as a choice.</p> <p>Facility staff have been re-in-serviced on the passing of evening snacks and on how to properly complete the PM Snack Audit Sheet. During Nightly PM Snack Rounds residents will be offered milk with their snacks. Each residents snack offer will be recorded on the PM Snack Audit Sheet.</p> <p>All PM Snack Audit Sheets will be reviewed by the facility DON, or designee, on a weekly basis for a period of 30 days, then bi-weekly for an additional 30 day period and then monthly thereafter. All audit results will be reviewed at the facility Monthly QPI Meetings for the next 90 days and then monthly thereafter. Any negative findings will be immediately addressed by facility Administrator, or designee.</p> <p>Completion Date: 3-8-13</p>				

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	<p>Council...then communicate its decisions to the Council...". A sample of the Resident Council Meeting Minutes is included with the policy and had a place for the Administrator's signature and date signed. There was also a sample titled Resident Council Requests that was used for follow up. The form requested a date, topic, request, and facility follow up.</p> <p>2-8-13 at 10:08 am an interview was conducted with Resident #36 and Resident #43, they both indicated they were not offered milk or any other beverage last night. They were given a nutrigrain bar. " No drinks were offered", stated Resident #36.</p> <p>2-8-13 at 10:20 a.m. interview with the DON indicated the CNA's were instructed to past the thickened liquids, juices, and milk last night. She did a verbal audit with the residents this morning and realized the liquids were not offered.</p> <p>No further documentation was provided to indicate the administration responded to the Resident Council grievance from the 12/7/12 meeting.</p> <p>3.1-3(1)</p>						

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper assessments were done before administering prescribed medications to 2 of 10 residents observed for medication administration. Resident #21, Resident #30</p> <p>Findings include:</p> <p>1. On 2/7/13 at 8:15 A.M., record review for Resident #21 indicated her</p>	F0329	<p>F-329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>The facility will ensure that proper assessments are being done before the administration of prescribed medications to residents.</p> <p>Resident's # 21 and #30 charts were reviewed and care plans were updated as necessary to reflect residents current status.</p> <p>All residents have the potential to</p>	03/08/2013			

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	<p>diagnoses included but were not limited to "...CAD [coronary artery disease], cardiac stent placement, chest pain, hypertension...". Physician order dated 1/27/2009 indicated to give "...Metoprolol Succinate Extended Release (medication for high blood pressure) 25 mg [milligrams] orally once a day..Hold if AP [apical pulse] < [less than] 50...."</p> <p>On 2/7/13 at 9:09 A.M., LPN #3 was observed during medication pass to administer Metoprolol Succinate ER 25 mg by mouth to Resident #21 without checking an apical pulse first.</p> <p>On 2/7/13 at 9:41 A.M., interview with LPN #3 indicated she was unsure about how often vital signs are completed on Resident #21, "...Maybe once a month? I'm not sure...None done today...."</p> <p>On 2/7/13 at 1:00 P.M., a copy of Resident #21's MAR (Medication Administrator Record) was obtained from the DON which showed there was no apical pulse charted for 2/6/13 or 2/7/13 when Metoprolol was given.</p> <p>2. On 2/7/13 at 1:00 P.M., record review for Resident #30 indicated her diagnosis included but were not limited to "...hypertension...".</p>		<p>be effected by this deficient practice. Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.</p> <p>All facility nurses have been re-in-serviced on the proper Policy & Procedures of assessing a resident prior to the administration of prescribed medications. This information, per facility policy, will be recorded in the resident's MAR document at the time of medication administration.</p> <p>The facility DON, or designee, will review all MAR's documents on a daily basis for a 30 day period to ensure that all assessments are completed and that all prescribed medications are given per doctor's orders. The facility Don, or designee will then review the MAR documents bi-weekly for an additional 30 day period and then monthly thereafter. All MAR's Audit results will be reviewed at the facilities Monthly QPI Meetings for a period of 90 days to ensure that all staff are completing their pre-medication assessments per facility policy.</p> <p>All residents have the potential to be effected by this deficient practice. All facility nurses have</p>				

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	<p>Physician order dated 6/7/12 indicated to give "...Metoprolol Tartrate 12.5 mg orally twice a day...Hold for HR (heart rate) <50...."</p> <p>On 2/7/13 at 9:44 A.M., LPN #3 was observed during medication pass to administer Metoprolol Tartrate 12.5 mg by mouth to Resident #30 without checking a heart rate first.</p> <p>On 2/7/13 at 10:46 A.M., observation of the MAR for Resident #30 indicated LPN #3 had not yet signed off giving Metoprolol.</p> <p>On 2/7/13 at 12:54 P.M., observation of the MAR for Resident #30 indicated LPN #3 had signed off Metoprolol 12.5 mg orally at 9 A.M. and had charted a heart rate of 72. Interview with LPN #3 at this time indicated she just took the pulse now, 4 hours after giving the medication.</p> <p>On 2/7/13 at 1:45 P.M., interview with DON indicated if there is a doctors order to check a pulse before giving a medication then the nurse should follow this order and check a pulse first.</p> <p>Review on 2/7/13 at 6:00 P.M., of the current "Medication Administration" policy, effective date 1/2001, revised</p>		<p>been re-in-serviced on the proper Policy & Procedure for medication administration and how to conduct pre-administration assessments. This information, per facility policy, will be recorded in the MAR document at the time of medication administration.</p> <p>The facility DON, or designee, will review all MAR's on a daily basis for a period of 30 days in order to ensure that all assessments are completed and that the prescribed medications are given per physician orders. The DON, or designee, will monitor all MAR documents bi-weekly for an additional 30 days and then monthly for a final 30 day period of time to ensure compliance..</p> <p>Completion Date: 3-8-13</p>				

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	11/2012, indicated "...perform necessary assessments prior to administering specific medications which may include, but is not limited to: pulse...." 3.1-48(a)(3)				

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F0371 SS=C	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on interview and record review, the facility failed to ensure that dietary employees knew the proper procedure to calibrate food thermometers. This had the potential to affect 52 of 52 current residents.</p> <p>Findings include:</p> <p>On 2/4/13 at 10:00 a.m., during record review of the kitchen temperature logs, no log sheet for thermometer calibration was noted. Interview with the Dietary Manager indicated she does not have a log sheet for thermometer calibration.</p> <p>On 2/6/13 at 11:30 a.m., interview with the Dietary Manager indicated the proper way to calibrate a dial thermometer was to place it in a cup of water, and the thermometer should be calibrated two times a week. She further indicated the staff normally use digital thermometers, but dial thermometers are available for use and the staff should know the proper</p>	F0371	<p>F-371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>The facility will procure food from sources approved or considered satisfactory by Federal, State, or local authorities and store, prepare, distribute and serve food under sanitary conditions. The facility will ensure that dietary employees know the proper procedure to calibrate food thermometers.</p> <p>All residents have the potential to be affected by this deficient practice. Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per facility policy.</p> <p>All Dietary staff have been re-in-serviced on the facility policy and procedure for sanitation, calibration and proper use of a food thermometer in order to ensure accurate food temperature during food preparation and service..</p>	03/08/2013			

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	<p>procedure to calibrate them.</p> <p>On 2/6/13 at 1:30 p.m., record review of the current policy titled "Nutrition Services Practice Manual" received from the Dietary Manager indicated, "...Accurate temperatures will be taken using a thermometer during preparation, cooking, meal service, and storage...Calibrate the thermometer as needed to make sure it is accurate...Calibrate thermometers using the ice point method...Fill a large glass with crushed ice. Add clean tap water until the glass is full and stir well. Put the thermometer stem into the ice water so that the sensing area...is completely submerged...Wait 3 minutes until the indicator stops moving. The thermometer should read 32 degrees F....".</p> <p>3.1-21(i)(3)</p>		<p>The Dietary Services Manager, or designee, will monitor staff use of food thermometers at one meal service per day during their normally scheduled days to work for a period of 30 days; one meal per week for an additional period of 30 days and then monthly thereafter to ensure that Dietary staff understand how to use a food thermometer per facility policy.</p> <p>All observation audits will be included in the Dietary Managers report and discussed at the facility Monthly QPI Meetings for a period of 90 days; any negative findings will be addressed immediately by the facility Administrator, or designee.</p> <p>Completion Date: 3-8-13</p>				

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure there was an accurate system in place for reconciliation of liquid</p>	F0431	<p>F-431 483.60(b), (d), (e) DRUG RECORDS. LABELS/STORE DRUGS AND BIOLOGICALS</p> <p>The facility will employ or obtain</p>	03/08/2013			

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	<p>controlled substances for 2 of 3 med carts observed. (North hall cart and Middle cart).</p> <p>Findings include:</p> <p>1. On 2/7/13 at 3:50 P.M., Guafenesin with Codeine (medicine for cough) was observed in the Middle hall medication cart ordered for Resident #6. The narcotic count log for resident indicated there was 80mL's (milliliters) left in bottle. Observation of the bottle of cough medicine showed there was more than 80mL's left. Interview with RN #2 indicated that without looking at the narcotic log sheet, she would estimate there was "...at least 90mL's left...". Resident #6's prescribed dose was "...10mL's PO (by mouth) Q4 (every 4 hours) prn (as needed)...."</p> <p>On 2/7/13 at 3:55 P.M., interview with RN #2 indicated "...medication bottles always come overfilled by pharmacy. This happens all the time...."</p> <p>2. On 2/7/13 at 4:00 P.M., a new sealed bottle of liquid Morphine sulfate (medicine for pain) was observed in the North hall medication cart ordered for Resident #51. The observed bottle of Morphine sulfate had an indicated strength of</p>		<p>the services of a licensed pharmacist who establishes a system or records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Resident # 6 and #51 charts and care plans were reviewed to reflect current status. All residents who have been prescribed liquid narcotics have the potential to be effected by this deficient practice. Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per facility policy.</p> <p>The facility nurses have been re-in-serviced on the facility P & P for the monitoring and administration of liquid narcotics. The nursing staff will continue, per facility policy, to perform narcotics counts at the change of shifts, and record the results on a Narcotics Count Sheet (this includes all liquid narcotics). The contract pharmacy for the facility has been contacted and agreed to make the Systemic Change of opening all liquid narcotic containers received from the manufacturer, recalibrating the zero amount, and labeling the bottle as such, before being</p>				

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	<p>100mg/5mL (20mg/mL) and the prescribed dose for Resident #51 was "...0.5 mL's PO Q3 hours prn pain...". The narcotic log sheet for resident indicated this was a new bottle and was filled to 30mL's. Observation of the bottle showed it was filled to more than 30mL's. Interview with RN #2 indicated the bottle was filled to "...at least 35 mL's...pharmacy always does this...."</p> <p>On 2/8/13 at 10:20 A.M., interview with the DON (Director of Nursing) indicated there was "...no policy in place to account for medication overfill from pharmacy...." DON also indicated she was not sure how nurses on the floor handled the situation if all the documented doses were gone but there was still medicine left in the bottle because there was no way to account for this extra or document wasting.</p> <p>3.1-25(e)(2) 3.1-25(e)(3)</p>		<p>shipped to the facility.</p> <p>The facility DON, or designee, will monitor all Narcotic Count Sheets daily on the normal days that she works, for a period of 30 days, then twice weekly for an additional period of 30 days and then monthly thereafter to ensure compliance .</p> <p>All Narcotics Count Sheets audit results will be reviewed at the facility Monthly QPI Meetings where trends will be discussed and all required action(s) will be taken.</p> <p>Completion Date: 3-8-13</p>		

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F9999	<p>3.1-14 PERSONNEL</p> <p>As indicated in subsection (t), a physical examination shall be required for each employee of a facility within one (1) month prior to employment which includes a tuberculin skin test. For health care workers who have not had a documented negative tuberculin skin test within the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure facility staff had been given the baseline tuberculin skin testing employing the two-step method for 1 of 10 sampled employees.</p> <p>Findings include:</p> <p>On 2/07/13 at 8:30 AM, ten (10) employee records were reviewed</p>	F9999	<p>F-9999 3.1-14 PERSONNEL</p> <p>The facility will ensure that all facility staff have been given the baseline tuberculin skin testing employing the two-step method as part of the new hire process.</p> <p>All employees have the potential to effected by this deficient practice.</p> <p>The facility DON, or designee, will ensure that each new employee hired has been given both steps of their two-step tuberculin test per facility policy.</p> <p>The facility Administrator, or designee, will review each new employee file prior to their 30 day anniversary to ensure that all required testing procedures have been completed including both steps of the two-step tuberculin test.</p> <p>All processes completed will be recorded on the New Employee Personnel File Check-off List and placed in the new hires file for permanent storage in the Business Office.</p> <p>The New Employee Personnel File Check-off List results will be reviewed at the facility Monthly</p>	03/08/2013	

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	<p>which indicated Employee # 8 received step one of the tuberculin skin test on 11/14/12, which was read on 11/16/12, as negative. The tuberculosis screening record lacked documentation that step two of the tuberculin skin test was given to Employee #8.</p> <p>On 2/07/13 at 10:02 AM, the Director of Nursing was interviewed and indicated Employee #8 had not received step two of the tuberculin skin test.</p> <p>On 2/07/13 at 5:58 PM, the facility's policy for Tuberculosis Screening (Infection Control Manual; 11.4.1) was received from the DON as current. The procedure indicated the facility will complete and read the first step of the tuberculin skin test of an employee prior to employment and "administer second step no less than one week and no more than three weeks after a negative result from the first step or according to state/federal regulation."</p> <p>3.1-14(t)</p>		<p>QPI Meetings each month to ensure that all required documentation has been completed and that all necessary action has been taken.</p> <p>Completion Date: 3-8-13</p>		