

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2016
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00195909.</p> <p>Complaint IN00195909-Substantiated. Residential deficiencies related to the allegation are cited at R144 and R237.</p> <p>Survey dates: July 27 and 28, 2016.</p> <p>Facility number: 011274 Provider number: 011274 AIM number: N/A</p> <p>Census bed type: Residential: 102 Total: 102</p> <p>Census payor type: Medicaid: 98 Other: 4 Total: 102</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by #02748 on July 30, 2016.</p>	R 0000	By submitting the enclosed material we are not admitting that the specific findings and or allegations are accurate. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective August 28, 2016 to the state findings of the State Residential Survey and Complaint Survey conducted on July 27 and 28, 2016	

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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R 0144 Bldg. 00	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the building was maintained in a clean and or in good repair for 2 of 8 residents rooms and 1 of 2 residents reviewed for bed bugs. Rooms were observed to have a deceased bug, dirt build up on the floor, cat litter on the floor, a white powder substance on shelving in the bathroom, soiled depends in the trash can, and a corroded faucet. (Room #631, Room #606, Resident #33, Resident #77, Resident #102)</p> <p>Findings include:</p> <p>1. On 7/27/16 at 9:30 a.m., an observation of Room #631 was made. The floor behind the door leading into the room was observed to have debris built up around the edges of the wall. Two shelves on the wall in the bathroom were observed to have a build up of a white powder substance. The sink faucet was</p>	R 0144	<p>Rooms 631 and 606 were immediately cleaned by housekeeping staff. The faucet in 631 has been replaced. The lift chair owned by resident # 33 has been re-treated for bed bugs, passed canine inspection and returned to resident's room. A house wide inspection of each resident's room has been conducted to identify any housekeeping concerns, including cleanliness of floor, shelves, trash cans and sink faucets. All areas of concern have been promptly corrected. In addition a house wide inspection for bed bugs has been conducted and treated as necessary. The measures or systematic changes that have been put into place to ensure that the concern does not recur is that the facility as in-serviced housekeepers on cleaning tasks. Facility has contract with bed bug inspection company and pest control company to identify and treat any bed bug activity in a speedy manner. This inspection will be conducted on a monthly</p>	08/28/2016

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	<p>observed to be corroded. A trash can was observed to be overflowing with soiled depends.</p> <p>On 7/28/16 at 1:00 p.m., an interview was conducted with Housekeeper #2. Housekeeper #2 indicated that resident rooms are mopped, swept, dusted, and the trash was emptied daily. She further indicated the same is done in the residents bathroom, including cleaning the toilet.</p> <p>2. On 7/27/16 at 1:50 p.m., Room #606 was observed. A deceased bug was observed on the floor. In the bathroom, cat litter was observed to be spread across the bathroom floor.</p> <p>On 7/28/16 at 1:55 p.m., the Housekeeping Supervisor indicated all resident rooms are swept, mopped, trash removed, and bathrooms cleansed daily. The cleaning schedules lacked a detailed description of the duties to be completed daily for resident rooms.</p> <p>3. During an observation on 7/27/16 at 10:40 a.m., Resident #33 was observed to be lying in a recliner. Resident #33 indicated the recliner was difficult to get out of as he had paralysis from a stroke on the left side. Resident #33 indicated he had been to the emergency room (ER)</p>		<p>basis.</p> <p>The corrective action will be monitored to ensure that the deficient practice will not recur through the quality assurance program by a Quality Assurance tool has been developed and implemented to monitor for the cleanliness of resident rooms and that the rooms are pest free. This tool will be completed by the Administrator or designee weekly for four weeks, then monthly for three months and quarterly for one quarter.</p>	

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	<p>on 7/10/16 and the bed bugs were noted on the him. Resident #33 indicated the facility had moved him to another room upon his return to the facility on 7/11/16. Resident #33 indicated when he returned to the room where he resided, the facility had sprayed his room for the bed bugs. The resident indicated the facility had removed his lift chair and placed it in storage as the chair had been infected with bed bugs.</p> <p>During an interview on 7/28/16 at 9:35 a.m., LPN #2 indicated bed bugs were found on Resident #33 when he arrived in the ER. LPN #2 indicated the facility had a dog detector for bed bugs inspect the resident's room, but the dog had not found bed bugs the first time he inspected the resident's room. LPN #2 indicated bed bugs were located in the resident's lift chair after the room had been treated and the lift chair was put into storage at the facility.</p> <p>During an interview on 7/28/16 at 12:15 p.m., the Administrator (Adm) indicated if a resident's piece of furniture was infected with bed bugs, the facility would either dispose of the furniture into a dumpster or place it in storage at the facility. The Adm indicated she was uncertain if the furniture was contained in plastic when it was placed in storage.</p>			

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R 0237 Bldg. 00	<p>A policy and procedure for bed bugs, undated and obtained from the Adm on 7/28/16 at 4:00 p.m., indicated the following: "The resident would be showered immediately and the clothes they were wearing would be washed. Clean clothes for several days should be placed in the dryer and dried clothes should be moved to a different room, if available. The pest control company would be contacted to begin step 2 (two) treatment. After both steps of treatment were complete, the pest control company would have a detection dog return to determine if any problems remained. After the room and it contents were cleared, the resident would return to their room. The mattress and box springs would be encased with a bed bug mattress cover."</p> <p>This Residential tag relates to Complaint IN00195909.</p> <p>410 IAC 16.2-5-4(a) Health Services - Deficiency (a) Each resident shall have a primary care physician selected by the resident</p> <p>Based on observation, interview, and</p>	R 0237	There is not a regulation that states how often a resident must be seen a physician. Resident	08/28/2016			

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	<p>record review, the facility failed to ensure a resident had a physician for 1 of 2 residents. A resident indicated he had not been visited by and/or visited his physician for over a year. (Resident #33)</p> <p>Findings include:</p> <p>On 7/27/16 at 1040 a.m., Resident #33 was observed to be lying in a recliner in his room.. Resident #33 was observed to have a visitor.</p> <p>On 7/27/16 at 10:56 a.m., Resident #33 and the visitor indicated the resident had been involved in an automobile accident on the evening of 7/10/16 and had been taken to the emergency room of a local hospital. Resident #33 indicated he had been released from the ER in the early morning hours of 7/11/16. Resident #33 and the visitor indicated it was the first time since last summer that the resident had seen a doctor. The visitor indicated she had taken the resident to the physician's office last summer, but the facility had offered the services of another physician's office who would come to the facility to see the resident. Resident #33 and the visitor indicated the new physician had never visited the resident, but only the nurse practitioners visited him.</p>		<p>#33 had selected a physician, Dr.Jackson who has a current medical practice in Evansville, Indiana was clearly identified on the chart binder. Resident was seen by Dr. Jackson's nurse practitioner on 6-17-16, 6-22-16 and 7-11-16. He was also seen by a physician in the emergency room after her was involved in a car accident on 7-10-16. A facility policy has been drafted and implemented that clarifies physician's visits. Accurate information is now listed on resident's facesheet. Resident # 33 has been seen by his physician. A house wide audit was completed to ensure that each resident is visited by their physician in accordance with facility policy as well as current physician listed on the facesheet. A mandatory in-service has been provided for all licensed nurses on the new physician visit policy as well as their responsibility to ensure that each resident is visited by their physician. Nursing and Admissions staff were in-serviced on properly documenting physician on facesheet. A Quality Assurance tool has been developed and implemented which will monitor the documentation in the clinical record to ensure that each resident is visited by their physician in accordance with facility policy. This tool will be completed by the Director of</p>				

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	<p>The clinical record for Resident #33 was reviewed on 7/27/16 at 10:09 a.m., Resident #33 had diagnoses including, but not limited to, CVA (cerebral vascular accident) with left hemiparesis, hypertension, diabetes mellitus type 2 (two), chronic kidney disease, hyperlipidemia, and was legally blind. Resident #33's "Emergency Information Record" indicated the attending physician was [Name of a Nurse Practitioner]. The cumulative physician's orders were signed by nurse practitioners for every other month from November, 2015, through June, 2016, with the exception of May, 2016, which was signed by the resident's physician. Visit notes, dated 1/28/16, 3/31/16, and 4/2/16, indicated the resident was seen by a nurse practitioner.</p> <p>During an interview on 7/28/16 at 11:45 a.m., the Adm (Administrator) indicated she had attempted to have the resident's physician see the resident, as well as other residents in the facility, but the physician would not visit. The Adm indicated the residents were only visited by the physician's nurse practitioners.</p> <p>During an interview on 7/28/16 at 1:35 p.m., the ADON (Assistant Director of Nursing) indicated the cumulative physician's orders which were signed on</p>		Nursing or designee weekly for four weeks, then monthly for three months and quarterly for one quarter. The outcome of this tool will be reviewed as the regularly scheduled Quality Assurance meeting to determine if any additional interventions are warranted.				

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R 0246 Bldg. 00	<p>5/5/16 by the physician had been hand delivered to the physician by one of the nurse practitioners and returned to the facility. The ADON further indicated the physician had never visited the resident.</p> <p>The facility lacked a policy on physician visits for the residents.</p> <p>This Residential tag relates to Complaint IN00195909.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on interview and record review,</p>	R 0246	The residents identified as resident #77, #102, #104 are	08/28/2016			

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	<p>the facility failed to ensure as needed medications administered by a QMA (Qualified Medication Aide) were authorized by a licensed nurse prior to administration for 3 of 8 residents reviewed. (Resident #77, Resident #102, Resident #104)</p> <p>Findings include:</p> <p>1. On 7/27/16 at 10:09 a.m., Resident #77's clinical record was reviewed. Resident #77's diagnoses included, but were not limited to anxiety and depressive disorder.</p> <p>The June MAR (Medication Administration Record) included, but was not limited to: Valium (an anti-anxiety medication) 10 mg (milligram) po (by mouth) prn (as needed). The medication administration record lacked a documented nurses authorization prior to administration by a QMA on 6/9/16, 6/14/16, 6/15/16, 6/20/16, 6/22/16, 6/23/16, 6/27/16, 6/28/16, 6/29/16, 6/30/16.</p> <p>2. On 7/27/16 at 10:00 a.m., a clinical record review was done on Resident #102. Resident #102 was given a PRN (as needed) medication by a QMA (Qualified Medication Aide) without a nurses signature. Resident #102 was</p>		<p>now receiving prn medications which have been authorized by a licensed nurse prior to the QMA administering the medication.</p> <p>The corrective action taken for the other residents having the potential to be affected by the same practice is that a house wide audit of clinical records has been conducted to identify any QMA who has failed to obtain authorization from a licensed nurse for the administration of a prn medication. Those Qmas that were identified have been counseled regarding failure to follow facility policy.</p> <p>A mandatory in-service has been conducted for all QMAs and licensed nurse regarding facility policy of prn medication administration and authorization</p> <p>The corrective action will be monitored through the quality assurance program by a Quality Assurance tool which will monitor the documentation of the licenses nurses for the administration of prn medications by the QMA. This tool will completed by Director of Nursing and or designee weekly for 4 weeks, then monthly for three months and then quarterly for one quarter The outcome of this tool will be reviewed at the regularly scheduled Quality Assurance meeting to determine if any additional interventions are warranted.</p>				

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R 0247 Bldg. 00	<p>given Benzonatate (Antitussive) 100 milligrams on 5/19/16.</p> <p>3. On 7/28/16 at 9:45 a.m., a clinical record review was done on Resident #104. Resident #104 was given a PRN medication by a QMA without a nurses signature. On 6/25/16, 6/27/16, 6/28/16, and 6/29/16, Xanax (Antianxiety) 0.25 milligrams was given, on 6/25/16, 6/27/16 and 6/29/16 Ultram 50 milligrams (Opiod) was given.</p> <p>On 7/28/16 at 9:40 a.m., the DON indicated licensed nurses should sign the back of the MAR when an as needed medication was administered by a QMA.</p> <p>On 7/28/16 at 1:32 p.m., the DON provided a policy and procedure related to medication administration, dated 5/2006. The policy included, but was not limited to:QMA's will inform the licensed nurse when a resident is in need of a PRN medication. The licensed nurse will sign off on the PRN medication with the QMA....</p> <p>410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are</p>						

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	<p>any actual or potential detrimental effects to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was given the correct dose of a medication for 1 of 7 medication observations. A resident received the incorrect amount of insulin. (Resident #29)</p> <p>Finding include:</p> <p>During an observation on 7/28/16 at 11:15 a.m., LPN #2 was observed to administer Humalog Insulin 100U/ml (units per milliliter) - 17 (seventeen) units into Resident #29's left upper arm. LPN #2 had indicated the resident's blood sugar results had been 229 mg/dl (milligrams per deciliter) prior to administering the insulin.</p> <p>During record review on 7/28/16 at 11:25 a.m., the clinical record indicated Resident #29 had a physician's order, dated 2/17/16, signed on 5/5/16, and obtained from the ADON on 7/28/16 at 1:45 p.m., for routine Humalog Insulin 100U/ml 15 units subcutaneous before meals. Resident #29 also had a physician's order, dated 1/28/16, for Humalog sliding scale insulin. The Humalog sliding scale insulin indicate</p>	R 0247	<p>The nurse identified as LPN #2 has been re-educated on the importance of ensuring that each resident received the appropriate amount of insulin in accordance with their physician's orders. A house wide audit of all insulin dependent diabetics has been completed. All insulin dependent diabetics are receiving their insulin in accordance with their physician's orders. A mandatory in-service has been conducted for all licenses nurses on the importance of ensuring that medications, including insulins are to be administered in accordance with each resident's physician's orders. A Quality Assurance tool has been developed and implemented to monitor the accurate administration of insulin. This tool will be completed by the Director of Nursing or designee weekly for four weeks, then monthly for three months and then quarterly for one quarter. The outcome of this tool will be reviewed at the regularly scheduled Quality Assurance meeting to determine if any additional interventions are warranted.</p>	08/28/2016			

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	<p>that for a blood sugar of 201 - 250 mg/dl the resident should receive 4 units of insulin. The resident's blood sugar at 11:05 a.m. was 229 mg/dl. The amount the resident should have received was 19 units total.</p> <p>On 7/28/16 at 11:30 a.m., LPN #2 was notified an incorrect dose of insulin was given to Resident #29. LPN #2 indicated she had given the resident 17 units but she should have given the resident 19 units of the Humalog insulin. LPN #2 indicated she would give the remaining 2 units to the resident immediately.</p> <p>The "Medication Error Report" obtained from the DON (Director of Nursing) on 7/28/16 at 1:32 p.m., indicated a precaution to avoid a medication error would be to re-educate the staff member to use the 5 (five) rights of medication administration prior to administering the medication.</p> <p>A policy for medication error reporting, undated, and obtained from the DON on 7/28/16 at 1:32 p.m., indicated a report should be filled out for all medication errors and the physician and family members would be notified.</p>			

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R 0272 Bldg. 00	<p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was handled in a safe and sanitary manner for 102 of 102 residents who ate food prepared from the kitchen. Gloves were not changed between task, hands were not washed, and food was stored on the floor. (Dietary Cook #1)</p> <p>Findings include:</p> <p>On 7/27/16 at 8:55 a.m., an initial tour of the kitchen was completed. On the tour, the following was observed:</p> <ol style="list-style-type: none"> Two dust pans and a broom were stored in front of the handwashing sink. French fries were stored on the floor in the freezer. The Dietary Manager removed the French Fries from the floor. The Dietary Manager brought a cup of coffee into the food preparation area. 	R 0272	<p>The broom and dust pans were immediately removed from the handwashing sink area. All food items in the freezer are stored on shelves and there are no food items stored on the freezer floor. There are no personal beverages in the food preparation area. All dry food items are closed and dated when placed into the dry food storage area. The dietary staff are now washing their hands and donning new gloves each time they prepare to do a new task involving the preparation of food To prevent other resident being affected by The items listed on the state survey, the broom and dust pans are now being stored in an appropriate area. All food items in the freezer are stored on shelves No personal beverages are to be taken into the food preparation area. The dietary staff are now washing their hands and donning new gloves each time they prepare to do a task involving the preparation of food A mandatory in-service has been provided for</p>	08/28/2016

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	<p>4. Penne noodles were stored unclosed and undated in the dry storage area. The Dietary Manager instructed a staff member to date the penne noodles.</p> <p>On 7/27/16 at 11:00 a.m., lunch preparation was observed. The observation included, but was not limited to:</p> <p>5. DC (Dietary Cook) #1 washed their hands and donned gloves. DC #1 placed a baked potato into the food processor and added cream. DC #1 placed the pureed baked potato into a pan and took the food processor to the dishwasher. DC #1 obtained frozen pureed peas and brought them to the food preparation counter. DC #1 removed their gloves and donned a new pair. DC #1 returned to the dishwasher to retrieve the food processor. DC #1 obtained stromboli meat. DC #1 placed the stromboli meat in the food processor and pureed it. DC #1 took the blade from the food processor and sat it on the food preparation table. DC #1 took the food processor blade to the dishwasher. DC #1 returned to the food preparation counter and then went back to the dishwasher to retrieve the food processor blade. DC #1 pureed an additional serving of stromboli meat. DC #1 covered the plate of pureed peas,</p>		<p>all dietary staff related to the safe and sanitary handling of food. This in-service included the proper storage of brooms and dust pans, the proper storage of foods in freezers and dry storage areas, the proper hand washing and donning of clean gloves between tasks and the practice related to the condition of the food preparation area which prohibits personal beverages being placed in the food prep. area</p> <p>The concerns noted on the state survey will be monitored through the quality assurance program. A Quality Assurance tool has been developed and implemented to monitor the safe and sanitary manner of handling/preparing food This tool will be completed by the Dietary Manager or designee weekly for four weeks, then monthly for three months and quarterly for one quarter The outcome of this tool will be reviewed at the regularly scheduled Quality Assurance meeting to determine if any additional interventions are warranted.</p>	

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	<p>potato, and stromboli meat and the pan of pureed stromboli meat and placed them in the steamer. DC #1 removed their gloves and donned a clean pair. DC #1 pureed strawberry cheesecake. DC #1 obtained rice and obtained a temperature. DC #1 took the rice to the steam table and returned to the kitchen. DC #1 retrieved stromboli's out of the oven and obtained a temperature. DC #1 obtained fish and obtained a temperature. DC #1 obtained baked potato's out of the steamer and obtained a temperature. DC #1 then placed the baked potato in the oven. DC #1 retrieved beets and obtained a temperature. DC #1 placed the beets back in the cooler. DC #1 then removed their gloves and washed their hands.</p> <p>On 7/28/16 at 8:06 a.m., the Dietary Manager indicated hands should be washed between glove changes.</p> <p>On 7/28/16 at 1:32 p.m., the DON provided the "Handwashing/Hand Hygiene" policy, undated. The policy included, but was not limited to: Employees must was their hands for at least forty-sixty (40-60) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions....after removing gloves or aprons.....</p>						

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R 0306 Bldg. 00	<p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on observation, interview, and record review, the facility failed to dispose of outdated medications for 6 of 102 residents and 4 of 4 nursing units. Eye drops were outdated and discontinued and insulins did not have an open date and/or were outdated. (Resident #15, Resident #25, Resident #33, Resident #59, Resident #60, Resident #101)</p>	R 0306	<p>All outdated or undated medications have been destroyed and reordered per facility policy and re-ordered where warranted on residents identified as #15, #25, #33 and #59, #60 and #101. A house wide audit was completed and all outdated medications have been destroyed and open dates have been noted. A mandatory in-service has been held for all licenses nurses and QMA's regarding their responsibility to check medications to ensure that all</p>	08/28/2016

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	<p>Findings include:</p> <p>1. On 7/28/16 at 8:40 a.m., the 300 unit and 400 unit medication cart were observed to have the following medications lacking an open date or outdated:</p> <p>Resident #15: Lantus Insulin 100U/ml with no open date listed Resident #15: Novolog FlexPen with no open date listed Resident #25: Victoza FlexPen with an open date of 6/19/16 Resident #33: Lantus FlexPen with an open date of 6/26/16.</p> <p>During an interview with LPN #2 indicated the expiration date for the Victoza FlexPen depended on how much medication the resident received but thought it was good for over one month and the Lantus FlexPen was good for at least one month.</p> <p>On 7/28/16 at 9:00 a.m., the 500/600 medication carts were observed to have the following medication which had been discontinued or outdated:</p> <p>Resident #59: Ketorolac 0.4% Ophthalmic Solution with an open date of 3/30/16 Resident #59: Tobramycin Ophthalmic</p>		<p>outdated medications are removed from the med cart and destroyed in accordance with facility policy</p> <p>A Quality Assurance Tool has been developed to ensure that outdated medications are disposed of in compliance with facility policy. This tool will be completed by the Director of Nursing or designee weekly for the first 4 week, then monthly for three months and then quarterly for one quarter. The outcome of this tool will be reviewed at the meeting to determine if any additional interventions are warranted.</p>	

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	<p>Solution 0.3% with an open date of 3/30/16 Resident #60: Pred Forte Ophthalmic Solution 1% with an open date of 6/22/16 Resident #101: Lantus Insulin 100U/ml with an open date of 6/25/16</p> <p>During an interview on 7/28/16 at 9:14 a.m., LPN #3 indicated Resident #59's Ketorolac and Tobramycin Ophthalmic Solutions should have been disposed of since the medications were given prior to the resident having ophthalmic surgery in March, 2016. LPN #3 further indicated the insulin should be discarded after 30 (thirty) days. LPN #3 indicated the pharmacy also checked for outdates and discontinued medications.</p> <p>According to the manufacturer's recommendations, Lantus Insulin and Novolog Insulin should be discarded 28 (twenty-eight) days after opening and the Vicotza FlexPen should be discarded 30 days after opening .</p> <p>According to the manufacturer's recommendation, Pred Forte Ophthalmic Solution should be discarded 30 days after opening.</p> <p>A policy for disposal of medications indicated medications awaiting disposal or return should be stored in a locked</p>			

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R 0349 Bldg. 00	<p>secure area designated for that purpose until destroyed or picked up by the pharmacy. The policy indicated medications should be removed from the medication cart immediately upon receipt of an order to discontinue the medication.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on observation, interview, and record review the facility failed to ensure clinical records were accurate for 1 of 7 residents reviewed. A resident did not have a physician's order for the use and care of continuous oxygen. (Resident #62)</p> <p>Findings include:</p>	R 0349	<p>A physicians order for continuous oxygen therapy was obtained immediately from the resident identified as # 62 immediately</p> <p>A house wide audit was completed and as a result all residents utilizing oxygen have physician's orders to support usage.</p> <p>A mandatory in-service was provided for all licensed nurses regarding the need for oxygen</p>	08/28/2016

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	<p>On 7/27/16 at 9:00 a.m., the ADON indicated Resident #62 received continuous oxygen.</p> <p>On 7/27/16 at 2:12 p.m., Resident #62's clinical record was reviewed. Resident #62's diagnoses included, but were not limited to: congestive heart failure and cough and congestion.</p> <p>The most recent physician's recapitulation orders, signed 5/26/16, lacked an order for continuous oxygen or the care of oxygen equipment.</p> <p>On 7/27/16 at 2:40 p.m., Resident #62 was observed wearing continuous oxygen.</p> <p>On 7/28/16 at 9:40 a.m., the DON indicated the nurse had noted the oxygen use in the nursing notes but there was not an order written. The DON further indicated she was obtaining an order clarification for Resident #62's oxygen use.</p> <p>On 7/28/16 at 1:32 p.m., the DON provided a policy and procedure related to medication administration, dated 5/2006. The policy included, but was not limited to: All medications is to be administered as prescribed.....</p>		<p>therapy. The in-service included a review of the facility policy and procedure on medication administration.</p> <p>A quality assurance tool has been developed and implemented to monitor residents receiving oxygen therapy to ensure that the appropriate physician's order is in place for oxygen usage. This tool will be completed by the director of nursing or designee weekly for 4 weeks, then monthly for three months and quarterly for one quarter. The outcome of this tool will be reviewed at the regularly scheduled Quality Assurance meeting to determine if any additional interventions are warranted.</p>	

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R 0410 Bldg. 00	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance</p> <p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to ensure annual tuberculin skin tests were administered for 1 of 8 residents reviewed. (Resident #77)</p> <p>Findings include:</p>	R 0410	Resident identified at #77 has received their annual tuberculin skin test A house wide audit was conducted on all residents and no other residents were found to be delinquent with the annual tuberculin skin test A tracking tool has been developed to monitor the date of the annual tuberculin skin test. A mandatory	08/28/2016

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R 0414	<p>On 7/27/16 at 10:09 a.m., Resident #77's clinical record was reviewed. Resident #77's most recent physician's recapitulation orders, signed on the April recapitulation order, undated, included, but was not limited to: Annual PPD due in May.</p> <p>The Immunization Record and TB (Tuberculosis) Screening/Risk Assessment indicated Resident #77's last tuberculin skin test was completed 5/14/15.</p> <p>On 7/28/16 at 9:40 a.m., the DON indicated residents should have an annual tuberculin skin test.</p> <p>On 7/28/16 at 10:58 a.m., the DON indicated Resident #77 had not received an annual tuberculin skin test.</p> <p>On 7/28/16 at 1:32 p.m., the DON provided the "Infection Control" policy, undated. The policy included, but was not limited to: Residents will if they so choose receive immunizations yearly or as prescribed.....</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency</p>		<p>in-service has been conducted for all licenses nurses on the facility policy related to tuberculin skin tests. The nurses were re-educated on their responsibility to ensure that each resident received their tuberculin skin test in a timely manner. A Quality Assurance tool has been developed and implemented to monitor the documentation of tuberculin skin tests to ensure that the test are annually given in a timely manner. This tool will be completed by the Director of nursing or designee weekly for four weeks, monthly for three months and quarterly for one quarter. The results will be reviewed at the regularly scheduled Quality Assurance meeting to determine if any additional interventions are warranted.</p>				

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Bldg. 00	<p>(k) 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>Based on observation and interview, the facility failed to ensure hand hygiene was provided during an accucheck and insulin injection. (Resident #29)</p> <p>Findings include:</p> <p>During an observation on 7/28/16 at 11:10 a.m., LPN #2 was observed to obtain an accucheck on Resident #29. LPN #2 was observed to enter the room with the resident, apply gloves and obtain the supplies for the accucheck. After obtaining the specimen, Resident #29 was given a tissue paper to hold against her finger which was bleeding. LPN #2 was observed to remove her gloves and reapplied clean gloves. LPN #2 obtained Resident #29's insulin. Resident #29 continued to have bleeding from their finger. LPN #2 obtained an alcohol wipe and wiped Resident #29's finger. LPN #2 removed her gloves and reapplied a clean pair. LPN #2 obtained a syringe, proceeded to draw up the insulin, and administered it to the resident. LPN #2 removed the gloves, picked up the glucometer with her bare hands, obtained an antimicrobial wipe, and proceeded to wrap the antimicrobial wipe around the</p>	R 0414	Resident identified as # 29 is now receiving their accuchecks and insulin administration in accordance with acceptable infection control practices The nurse identified ad lpn #2 is now performing accuchecks and administering insulin in accordance with acceptable standard of infection control practices All insulin dependent residents are receiving their accuchecks and administration of insulin in accordance with acceptable standards of infection control practices A mandatory in-service was provided for all licenses nurses on the facility's acceptable standards of infection control practices including hand washing and glove usage while performing accuchecks and the administration of insulin A quality Assurance tool has been developed and implemented to monitor the infection control practices during the performing of accuchecks and the administration of insulin. This tool will be completed by the Director of Nursing or designee weekly for four weeks, then monthly for three months and then quarterly for one quarter. The outcome of this tool will be reviewed at the regularly scheduled Quality Assurance meeting to determine if any additional interventions are	08/28/2016

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	<p>glucometer. LPN #2 laid the glucometer wrapped in the wipe onto a paper towel. LPN #2 obtained another antimicrobial wipe and wiped her hands.</p> <p>On 7/28/16 at 1:32 p.m., the DON provided the "Handwashing/Hand Hygiene" policy, undated. The policy included, but was not limited to: Employees must was their hands for at least forty-sixty (40-60) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions....after removing gloves or aprons.....</p> <p>During an interview on 7/28/16 at 1:33 p.m., the ADON (Assistant Director of Nursing) indicated hands should be washed prior to obtaining an accucheck, between obtaining a blood sugar, prior to administering insulin or a medication, and after the injection.</p>		warranted.	