

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155401	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2012
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NAME OF PROVIDER OR SUPPLIER BEN HUR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 S GRANT AVE CRAWFORDSVILLE, IN 47933
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 21, 22, 23, 24 and 25, 2012</p> <p>Facility number: 000461 Provider number: 155401 AIM number: 100275290</p> <p>Survey team: Rita Mullen, RN, TC Michelle Hosteter, RN Michelle Carter, RN</p> <p>Census bed type: SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare: 2 Medicaid: 68 Other: 11 Total: 81</p> <p>Sample: 17 Supplemental: 3</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2.</p>	F0000	Submission of this plan of correction shall not constitute or be construed as an admission by Ben Hur Home that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Ben Hur Home.	

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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	Quality review completed 6/5/12 by Jennie Bartelt, RN.			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of residents' condition changes resulting in a delay in treatment (Resident #57) and a delay in medical evaluation (Resident #</p>	F0157	1. I. Please note that on 3/15/12, Resident #57's physician was contacted to clarify the diet order	06/15/2012			

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	<p>24). This affected 2 out of 17 sampled residents reviewed for physician notification. (Residents #24 and 57)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #57 was reviewed on 5/22/12 at 3:00 P.M.</p> <p>Diagnoses for Resident #57 included, but were not limited to, Alzheimer's with dementia, hypertension (high blood pressure), osteoarthritis, obesity, hypothyroidism, seizure disorder, paranoid ideations, depression, acute renal insufficiency, hyperkalemia, history of UTI's (urinary tract infections), and aspiration pneumonia.</p> <p>Nursing notes, dated 3/15/12 at 1:25 P.M., indicated Resident #57 returned to the facility from a hospital stay with "DR (dark) purple area to Lt (left) buttock, 4 x 5 cm (centimeters) and DR purple area to coccyx, 3 x 1.0 cm, skin intact, calmoseptine applied." The physician was not notified.</p> <p>Nursing notes and skin assessments from 3/7/12 indicated Resident #57 was free of pressure areas to the buttock and coccyx areas prior to hospital admission on 3/11/12.</p>		<p>she returned with from the hospital, and at this same time he gave an order to "Resume preventative skincare as ordered prior to hospitalization". The area on the resident's buttocks actually improved prior to the visit by the wound nurse on 3/21/12, as it decreased in size from 4 cm. X 5 cm. to 3 cm. X 3 cm. The area to the resident's coccyx continues to improve and resolve.</p> <p>II. As all residents returning from a hospital stay could have changes in skin condition requiring revision of orders, facility staff have audited records of all residents who have been hospitalized during the last 30 days to ensure there were no changes in skin condition which were</p>				

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	<p>Nursing notes, dated 3/21/12 at 3:00 P.M., indicated, "Area on res. (resident's) coccyx reported to writer. Wound nurse here to eval (evaluate).....Family and MD notified." A Wound Documentation Form completed by the wound nurse practitioner on 3/21/12 indicated, "...new wound site at coccyx, deep tissue injury-evolving since hospital stay, 100% purple/yellow slough. Treatment plan: wound cleanser, Santyl, calcium alginate, skin prep, Alleyvn Adhesive. Change daily and PRN (as needed)." and "...new wound site to Left buttock, fragile new epithelium cover, 100% pink, smooth edges. Treatment plan: continue calmoseptine ointment after daily cleansing. "</p> <p>A fax to the physician, dated 3/21/12 (no time indicated), indicated, "...FYI. Upon return from hosp (hospital) res (resident) had area on buttock and coccyx. Preventative measures utilized until complete eval (evaluation) from wound nurse.....Deep tissue injury and treatment ordered."</p> <p>During an interview with the Director of Nursing on 5/24/12 at 10:15 A.M., she said the physician is usually not notified of a pressure area until a pressure area has actually opened.</p>		<p>not reported to the attending physician.</p> <p>III. As a means to ensure ongoing compliance, Licensed Nurses have received Inservice training conducted by the Director of Nursing to review and emphasize the importance of physician notification of changes in a resident's condition upon return from the hospital.</p> <p>IV. As a means of quality assurance, the Director of Nursing or her designee will review records on all residents readmitted to the facility from the hospital for changes in condition which require physician notification. Any failure of nursing staff to report changes appropriately will be addressed with the staff member involved through</p>				

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	A skin breakdown care plan goal, dated 7/21/11 and updated on 1/17/12, indicated, "I will have no skin breakdown with in the next 90 days." Interventions included, but were not limited to the following: "turn and reposition approximately every 2-3 hours and as needed, use pillows or blanket rolls to aid in positioning, and assist me to shift my weight at least every 2-3 hours." According to nursing notes from 3/15/12 to 3/21/12, care plan interventions were followed, the resident used a pressure reducing bed mattress and a pommel cushion while sitting in the wheelchair.		re-education. The Director of Nursing will report to the Administrator each week and to the Quality Assurance Committee during quarterly meetings any non-compliance of appropriate physician notification upon a resident's return from the hospital. 2. I. Please note that the Director of Nursing contacted the physician on call for Resident #24 on 5/24/12, asking if he would have given facility staff any different orders had he been informed of the resident's redness, bruising and swelling of the right arm following his fall on 4/14/12 other than to have him evaluated at his prescheduled orthopedic appointment		

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			<p>two days later. He indicated that he would not have given any other instructions without indication of a change in movement, a deformity, or severe pain – which the resident did not display.</p> <p>II. As all residents with a change in condition could be affected by appropriate physician notification, facility staff have reviewed 24 hour report books and follow up logs for the past 30 days to ensure there has been no failure of proper reporting to physicians.</p> <p>III. As a means to ensure ongoing compliance, the Director of Nursing has provided Inservice training to licensed nurses regarding appropriate notification to physicians of changes in resident's conditions, with specific</p>		

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	2. During the initial tour with		<p>emphasis on reporting of symptoms/injuries even though they may be an expected outcome of a known event.</p> <p>IV. As a means of quality assurance, the Director of Nursing or her Designee will audit 24 hour report books and follow up logs on scheduled days of work to ensure physicians are notified appropriately of changes or worsening resident conditions. The Director of Nursing will report to the Administrator on a weekly basis and the Quality Assurance Committee during quarterly meetings any failure of licensed nurses to appropriately report changes in conditions to physicians.</p>		

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	<p>theMinimum Data Set Coordinator on 5/21/12 at 10:15 A.M., she indicated Resident #24 had fractured both shoulders at different times.</p> <p>The clinical record of Resident #24 was reviewed on 5/22/12 at 10:10 A.M.</p> <p>Diagnoses for Resident #24 included, but were not limited to, Alzheimer's disease, depression and a history of falls.</p> <p>A Nursing note, dated 4/14/12 at 5:25 A.M., indicated, "Res (Resident) was sitting on edge of bed- CNA (Certified Nursing Assistant) turned his back, Res fell to floor onto [left] side. .5 cm (centimeter) abrasion near outer corner [left] eye- ice applied....Res c/o pain [left] eye only." The physician was not notified of the fall.</p> <p>A Nursing note, dated 4/14/12 at 8:25 A.M., indicated, "...c/o [right] shoulder pain. [no] redness, [no] busing, can raise are. Spoke [with] son....[no] injury noted @ this time...Also discussed Dr. appt (appointment) Mon (Monday) [with] [name of doctor]..." The physician was not notified of the complaint of right shoulder pain after a fall.</p> <p>A Nursing note, dated 4/14/12 at 12:25 P.M., indicated, "...Continues to c/o</p>						

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	<p>[right] shoulder pain. [no] busing, [no] redness...."</p> <p>A Nursing note, dated 4/14/12 at 1:00 P.M., indicated, "Paged [name of physician] on call for [name of physician]. Informed him of fall & c/o [right] shoulder pain. [name of doctor] stated to let [name of doctor] Know & have him assess Mon...." This was seven and a half hours after the fall.</p> <p>A Nursing note, dated 4/14/12 at 10:00 P.M., indicated, "Res c/o [right] shoulder pain. Has some bruising starting measuring 14.5 X 6 [centimeters]. Also an abrasion to [left] knee approx (approximately) 30 cm [centimeters] d/t (due to) early morning fall..." The physician was not notified of the Resident developing bruising or the abrasion to the left knee after the fall on 4/14/12 at 5:25 A.M. The physician was not notified.</p> <p>A Nursing note, dated 4/14/12 at 4:25 A.M., indicated, "...Bruise [right upper] arm bluish [with] yellow edge. Redness noted (sic) elbow crease...." The physician was not notified.</p> <p>A Nursing note, dated 4/15/12 at 12:25 P.M., indicated, "...[right] arm is bruise (sic) under armpit & inside of arm, faint in color....Medicated for pain [with]</p>			

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	<p>relief...." The physician was not notified.</p> <p>A Nursing note, dated 4/15/12 at 10:00 P.M., indicated, "Res still c/o [right] shoulder pain. Will be going to see [name of doctor] tomorrow...."</p> <p>A Nursing note, dated 4/16/12 at 5:30 A.M., indicated, "...Denies pain @ this time but states, "My arms are very sore," [right] upper arm & shoulder edematous, 2+ non pitting. Purplish, blackish-blue in color...." The physician was not notified of the Resident develpoing emema or the purple bruising of the right upper arm.</p> <p>A Nursing note, dated 4/16/12 at 12:30 P.M., indicated, "Res LOA (leave of absence) to appt. [with] [name of doctor]." 6/12 at 1:45 P.M., indicated, "Returned from appt., to be in immobilizer X 2 wks...."</p> <p>During an interview with the Director of Nursing (DoN), on 5/22/12 at 11:40 A.M., she indicated the staff called on Saturday and was told by the doctor that the resident could be seen on Monday at his doctor's appointment. Staff and doctor thought the right arm might be broken. She indicated the doctor said the ER (emergency room) "wouldn't have us do anything that we weren't already doing."</p>				

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	<p>A Checklist When Fall Occurs, recieved from the DoN on 5/22/12 at 11:30 A.M., indicated the following: "...5. Contact Doctor..."</p> <p>A Facility Policy received from the Director of Nursing, on 5/24/12 at 9:00 A.M., entitled "Notification of Changes" indicated the following:</p> <p>Purpose:</p> <p>To keep the Resident, legal representative (or family members), and physician (when applicable) aware of changes which affect the care and welfare of the Resident.</p> <p>Policy:</p> <p>This facility shall immediately inform the Resident, consult with the Resident's physician, and, if known notify the Resident's legal representative or an interested family member when there is :</p> <p>(1) an accident involving the Resident that results in injury and has the potential for requiring physician intervention...."</p> <p>3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to provide treatment for two deep tissue pressure wounds for Resident # 57 upon return from a hospital stay. This affected 1 of 4 residents reviewed for pressure ulcer prevention and treatment in a sample of 17. (Resident #57)</p> <p>Findings include:</p> <p>The clinical record for Resident #57 was reviewed on 5/22/12 at 3:00 P.M.</p> <p>Diagnoses for Resident #57 included, but were not limited to, Alzheimer's with dementia, hypertension (high blood pressure), osteoarthritis, obesity, hypothyroidism, seizure disorder, paranoid ideation's, depression, acute renal insufficiency, hyperkalemia, history of UTI's (urinary tract infections), and aspiration pneumonia.</p>	F0314	<p>I. Please note that the area on the resident's buttocks actually improved prior to the visit by the wound nurse on 3/21/12, as it decreased in size from 4 cm. X 5 cm. to 3 cm. X 3 cm. The area on her coccyx did not get any larger from the time of her readmission on 3/15/12 until she was seen by the wound nurse on 3/21/12, although on 3/20/12 nursing notes indicate it appeared to have a "slit-like area", which the wound nurse documented the next day as being .1 cm in depth. The area on the resident's buttocks has been healed since 4/18/12 and remains intact. The area to the resident's coccyx continues to improve and resolve, and now measures only 1.6 cm. X 0.2 cm. X 0.1 cm. Treatment to the areas was provided in accordance with the physician's order of 3/15/12 to "Resume preventative skin care as ordered prior to hospitalization". II. As all residents with pressure ulcers require appropriate treatment, a</p>	06/15/2012			

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	<p>Nursing notes and skin assessments from 3/7/12 indicated Resident #57 was free of pressure areas to the buttock and coccyx areas prior to hospital admission on 3/11/12.</p> <p>Nursing notes, dated 3/15/12 at 1:25 P.M., indicated Resident #57 returned to the facility from a hospital stay with "DR (dark) purple area to Lt (left) buttock, 4 x 5 cm (centimeters) and DR purple area to coccyx, 3 x 1.0 cm, skin intact, calmoseptine (an over the counter, multi-purpose, moisture barrier) applied." Notes failed to indicate the physician was notified.</p> <p>Nursing notes, dated 3/21/12 at 3:00 P.M., indicated, "Area on res. (resident's) coccyx reported to writer. Wound nurse here to eval (evaluate).....Family and MD notified."</p> <p>A weekly skin condition report, dated 3/21/12, indicated an unstageable pressure ulcer, measuring 3 x 1 x 0.1 cm, to the coccyx. Comments: "deep tissue since hospital stay 100% purple/yellow slough. Wound nurse eval and tx (treatment) ordered." This was six days after her return from the hospital when the areas to the coccyx and left buttock were first noted.</p>		<p>review has been conducted for all facility residents, and physicians' orders for treatment have been verified. The Care Planning Coordinator will review/revise each resident's care plan as interventions are added or deleted. III. As a means to ensure ongoing compliance, the Director of Nursing has provided Inservice training to licensed nurses on ensuring that physicians' orders are appropriate for decubitus ulcers – specifically addressing the need to assess upon readmission from the hospital for any changes/revisions to be requested of the physician. IV. As a means of quality assurance, The Director of Nursing or designee will review records of residents returning from hospital stays to ensure treatment orders for skin care continue to be appropriate. The Director of Nursing will report to the Administrator on a weekly basis and to the Quality Assurance Committee during quarterly meetings any failure to obtain appropriate orders for care of decubitus ulcers.</p>				

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	<p>A Wound Documentation Form, completed by the wound nurse practitioner on 3/21/12 indicated, "...new wound site at coccyx, 3 x 1 x 0.1 centimeters, deep tissue injury-evolving since hospital stay, 100% purple/yellow slough. Treatment plan: wound cleanser, Santyl, calcium alginate, skin prep, Alleyvn Adhesive. Change daily and PRN (as needed)...new wound site to Left buttock, 3 x 3 centimeters, fragile new epithelium cover, 100% pink, smooth edges. Treatment plan: continue calmoseptine ointment after daily cleansing. "</p> <p>During an interview with the Director of Nursing on 5/24/12 at 10:15 A.M., she said the physician is usually not notified of a pressure area until a pressure area has actually opened. A statement provided by the D.o.N. on 5/25/12 at 8:45 A.M. indicated the following:</p> <p>"Upon this resident's return from the hospital on 3/15/12, an intact deep tissue injury of the buttocks was noted to be present which was not present when she left. Nothing was noted by the hospital, and no treatment orders were given. Facility staff resumed the customary treatment order of calmoseptine ointment to the area, which was unstageable. The</p>				

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	<p>facility's contracted wound nurse evaluated the area on 3/21/12 and gave a new treatment order...."</p> <p>The American Medical Directors Association's Pressure Ulcers in the Long Term Care Setting Clinical Practice Guideline, 2008, indicated "a suspected Deep Tissue Injury is a purple or maroon localized area of discolored intact skin, blood filled blister....Evolution may be rapid, exposing additional layers of tissue even with optimal treatment."</p> <p>3.1-40(a)(2) 3.1-40(a)(3)</p>				

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation and interview, the facility failed to ensure sharps were not accessible to residents on a locked unit. This had the potential to affect 7 ambulatory residents of 17 residents residing in the facility's locked unit.</p> <p>Findings include:</p> <p>During the initial tour on 5/21/12 at 11:00 A.M., with the Director of Nursing on the locked unit, seven residents were identified as ambulatory.</p> <p>During the Environmental Tour with the Director of Maintenance on 5/22/12 at 2:00 P.M., a kitchen drawer in the locked unit's dining area was found to have six knives and four forks. The room was unattended, residents were walking in the hall and three residents were seated in the dining room with the unlocked drawer with the metal eating utensils.</p> <p>During an interview with QMA #1 (Qualified Medication Aide) on 5/22/12 at 2:00 P.M., she indicated the drawer</p>	F0323	<p>I. The butter knives and forks were removed from the unlocked drawer immediately upon notification of the concern and placed in a bag in a locked cabinet. II. As all ambulatory residents on the secured dementia unit could be affected by access to sharp items, the dining room area was thoroughly assessed for any other items which could pose a danger. III. As a means to ensure ongoing compliance, staff working on the secured unit were advised in writing of the new storage arrangements on 5/22/12. Again on 5/31/12, a written memo was distributed to all nursing staff working on the secured unit of the proper storage arrangements for knives and forks. The Director of Nursing has provided inservice training regarding security of potentially dangerous items to nursing staff. IV. As a means of quality assurance, the Administrator will be responsible to monitor at least weekly to ensure proper storage of items on the secured dementia unit. If noncompliance is observed, corrective action shall be taken immediately. Any failure of staff</p>	05/31/2012

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	should be locked or the the utensils removed. 3.1-45(a)(1)		to ensure proper storage of knives and forks on the secured unit will be reported by the Administrator to the Quality Assurance Committee during quarterly meetings.		

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was assessed for lung sounds before and after a nebulizer treatment. The deficient practice affected 1 of 1 resident reviewed related to nebulizer treatment in a supplemental sample of 3. (Resident #49)</p> <p>Findings include:</p> <p>During an observation on 5/23/12 at 1:35 P.M., LPN (Licensed Practical Nurse) #3 was giving Resident #49 a nebulizer treatment. LPN #3 checked the medication and then went to the resident and placed a pulse oximeter (device that measures the oxygen level in the blood) to verify the resident's oxygen saturation level and heart rate. LPN #3 placed medication into the chamber of the mouthpiece and turned on the nebulizer machine. The resident finished the</p>			F0328	<p>I. The Licensed Nurse who failed to assess breath sounds during the nebulizer treatment for Resident #49 was immediately addressed by the Director of Nursing and reminded of the proper procedure. II. As all other residents who receive nebulizer treatments could be affected by a failure to conduct lung assessments appropriately, on 5/31/12 Licensed Nurses received a copy of the facility policy for conducting nebulizer treatments as a reference for future performance of treatments. III. As a means to ensure ongoing compliance, Licensed Nurses have received Inservice training conducted by the Director of Nursing to review and emphasize the importance of completing lung assessments during nebulizer treatments. IV. As a means of quality assurance, the Director of Nursing or her Designee will monitor at least weekly to ensure that nebulizer treatments are being conducted</p>		06/15/2012

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	<p>medication, and LPN #3 then rechecked the oxygen saturation level. Afterwards, LPN #3 signed the MAR (Medication Administration Record).</p> <p>During an interview with LPN #3 on 5/23/12 at 1:40 P.M., she indicated this is all she does during a nebulizer treatment for the residents.</p> <p>During an interview with the DoN (Director of Nursing) on 5/23/12 at 2:00 P.M., she indicated she would expect the nurses to assess lung sounds during a nebulizer treatment.</p> <p>A policy titled "Nebulizer, Hand held (Small Volume) and dated 11/01 with revision dates of 11/03, 3/04 and 8/23/04 was provided by the DoN on 5/24/12 at 9:00 A.M. Review of the policy indicated, "...5. Assess Resident and establish baseline respiratory rate, heart rate, and breath sounds..."</p> <p>3.1-47(a)(6)</p>		<p>appropriately by licensed nurses. If noncompliance is observed, corrective action shall be taken immediately. Any failure of staff to complete nebulizer treatments in accordance with facility policy will be reported by the Director of Nursing to the Administrator on a weekly basis, and also to the Quality Assurance Committee during quarterly meetings.</p>		

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F0431 SS=E	<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, record review, and interview, the facility failed to ensure medications stored on the facility's locked unit were properly locked-up. This had</p>	F0431	I. The QMA responsible for leaving the medication cabinet unlocked and unattended was addressed by the Administrator immediately upon notification of	06/15/2012			

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	<p>the potential to affect 7 ambulatory residents of the 17 residents residing on the locked unit.</p> <p>Findings include:</p> <p>During the Initial Tour on 5/21/12 at 11:00 A.M., with the Director of Nursing on the locked unit, seven residents were identified as ambulatory.</p> <p>On 5/22/12 at 2:00 P.M., during the Environmental Tour with the Director of Maintenance on the locked unit, the kitchen wall cabinet in the dining area, where the residents' medications were stored, was found to be un-locked. The room was unattended by staff at that time, and residents were walking in the hall and three residents were seated in the dining room.</p> <p>During an interview with QMA #1 (Qualified Medication Aide) on 5/22/12 at 2:00 P.M., she indicated the medication wall cabinet should be locked. She indicated had just stepped out of the room to give another resident their medications and had not locked the medication cabinet when she left.</p> <p>Review of the facility policy titled, "Medication Storage in the Facility" indicated the following: "Medications</p>		<p>the concern. II. As all cognitively impaired residents could be affected by access to unsecured/unattended medications, all other licensed nurses and Qualified Medication Aides were made aware of the concern in writing on 5/31/12. III. As a means to ensure ongoing compliance, the Director of Nursing has provided QMA #1 with one-to-one re-education in relation to ensuring that medications are never accessible to residents or out of visual supervision. Licensed Nurses and QMAs have received inservice training on security of medications. IV. As a means of quality assurance, the Director of Nursing or her Designee will be responsible to monitor daily on scheduled days of work to ensure that medication rooms, cabinets, and carts are properly secured. If noncompliance is observed, corrective action shall be taken immediately. Any failure of staff to ensure proper security of medications will be addressed by the Director of Nursing, and reported to the Administrator on a weekly basis, as well as to the Quality Assurance Committee during quarterly meetings.</p>				

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	and biologicals are stored safely, securely, and properly following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed/qualified nursing personnel or pharmacy personnel...." 3.1-25(m)			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure</p>	F0441	1. I. Facility policy for blood glucose monitoring and	06/15/2012	

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	<p>proper disinfection of glucometers according to manufacturer's specifications and facility policy. This affected 1 of 1 glucometer disinfection observed during blood sugar checks. The facility also failed to ensure completion of a second step tuberculin (TB) test for 1 of 17 residents reviewed related to TB screening in a sample of 17 . (Residents #17, #31 and #39)</p> <p>Findings include:</p> <p>1. During medication pass on 5/23/12 at 10:50 A.M., LPN #2 was observed completing a blood sugar check for Resident #17. LPN #2 wiped glucometer #1 clean with a disinfectant wipe for 5 seconds, and then set glucometer #1 down on a paper towel to dry at 10:55 A.M. LPN #2 then picked up glucometer #2 and used it to check Resident #39's blood sugar. She completed the same steps of wiping down glucometer #2 and wiping it down for 5 seconds and setting on a paper towel to dry. LPN #2 then picked up glucometer #1 at 10:58 A.M. The time frame she wiped down the glucometer was five to ten seconds and the drying time between alternating glucometers was three minutes.</p> <p>At this time, review of the label on the disinfectant wipes titled "PPS Select</p>		<p>disinfection of devices has been reviewed and revised as indicated below. II. As all residents who require blood glucose monitoring could be affected by facility policy for use of devices, the facility policy now requires individual glucometer devices assigned to each specific resident requiring testing. III. Glucometers have been obtained, calibrated, and assigned to every resident who currently has an order for blood glucose monitoring. Each device is labeled with the resident's name, and stored in a carrying case which is also identified with the specific resident's name. Per the attached policy, glucometers will never be used for more than one resident, thus not requiring disinfection between uses on the same resident. Back up glucometers are available to staff in the event of a malfunction or unavailability of a specific resident's own personal glucometer. The Director of Nursing has provided inservice training to nursing staff on this new policy, which was implemented on 6/7/12. IV. As a means of quality assurance, the Director of Nursing or her Designee will be responsible to monitor daily on scheduled days of work to ensure that blood glucose monitoring is being conducted in accordance with the new facility policy, and that glucometers are not exchanged between residents. If</p>				

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	<p>Disinfectant/Deodorizing/ Cleaning Wipes" indicated, "...Disinfection: Thoroughly wet...surface with a wipe, keep wet for 2 minutes...allow to air dry. Use as many wipes as needed for the treatment surface to remain wet for the entire contact time...."</p> <p>In an interview with LPN #2 on 5/23/12 at 11:10 A.M., she indicated this is the procedure she usually uses regarding disinfecting and using the glucometers to do blood sugars for the residents.</p> <p>A policy titled, "Blood Glucose Monitoring" provided by the DoN on 5/24/12 at 9:00 A.M., revision date of 4/13/12, indicated, "...1. ..To disinfect the glucometer, thoroughly wet the device with the PPS wipe and let it set to air dry for five minutes...."</p>		<p>noncompliance is observed, corrective action will be taken immediately. Any failure of staff to ensure compliance with the revised facility policy for blood glucose monitoring implemented on 6/7/12 will be reported to the Administrator on a weekly basis, as well as to the Quality Assurance Committee during quarterly meetings. 2. I. Resident #31 was administered another PPD on 5/24/12, which was read on 5/27/12 and was negative. A 2nd step PPD was then given on 6/4/12, and read as negative on 6/6/12. Tuberculin PPD testing will now be completed annually for this Resident. II. As all residents could be affected by obtaining proper immunization testing, the facility has revised its practice for new admissions as follows: III. For each resident requiring a 2nd step PPD on admission, the nurse completing the admission process will note the date the 2nd step PPD is due (1 to 3 weeks after the first test) on the resident's Medication Administration Record, as well as the desk calendar of resident appointments. Additionally, the dates for reading both the first step and 2nd step PPD tests will be marked on the MAR at the time the initial PPD is given. The Director of Nursing has provided inservice training to licensed nurses on this new practice, and will monitor on all new admissions</p>	

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	<p>2. The clinical record of Resident #31 was reviewed on 5/23/12 at 2:00 P.M. Resident #31 was admitted to the facility on 7/21/11.</p> <p>The immunization record indicated Resident #31 had a tuberculin (TB) skin test on 7/22/11. The results were read on 7/25/11 and were negative. There was no second step TB skin test.</p> <p>During an interview with the Director of Nursing on 5/24/12 at 1:00 P.M., she indicated a second step TB skin test could not be found.</p> <p>A policy for "Tuberculin Skin Test Upon Admission to Nursing Facility" received from the facility Administrator, on 5/25/12 at 10:00 A.M., indicated the</p>		<p>that PPD testing is conducted appropriately. IV. As a means of quality assurance, the Director of Nursing or her Designee will review the records of all new admissions to ensure appropriate immunization testing has been completed and documented, and will report to the Administrator on a weekly basis any failure of nursing staff to properly administer tuberculin testing. Additionally, the Director of Nursing will report at quarterly Quality Assurance meetings any lack of proper tuberculosis testing for any new admissions.</p>				

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	<p>following:</p> <p>"It is the policy of this facility that a tuberculin skin test shall be completed within three (3) months prior to admission or within the first 24 hours of admission and read at forty-eight (48) to seventy-two (72) hours afterward....</p> <p>The baseline tuberculin skin testing shall employ the two-step method. For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing shall employ the two-step method. If the first step in negative, a second test shall be performed within one (1) to three (3) weeks after the first test."</p> <p>3.1-18(b)(2) 3.1-18(f)</p>				

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F0456 SS=E	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observation and interview, the facility failed to have a functioning call-light in the common resident dining area of Wing 2, where 11 residents resided. This affected 1 of 4 dining areas.</p> <p>Findings include:</p> <p>During the Environmental Tour with the Director of Maintenance on 5/22/12 at 1:25 P.M., the call-light in the residents' dining area on Wing 2 was observed to be non-functioning.</p> <p>During an interview with the Director of Maintenance on 5/22/12 at 1:25 P.M., after he had inspected the call-light, he indicated the plug-in socket for the call-light was broken.</p> <p>3.1-19(u)(3) 3.1-19(bb)</p>	F0456	<p>I. The call light in the residents' dining area on Wing 2 was repaired the same day it was noted to be malfunctioning during the survey – 5/22/12. II. All other call lights on Wing 2 were checked to ensure they were functioning properly – no other problems were noted. III. As a means to ensure ongoing compliance, the Director of Maintenance will check for proper function of the facility's call light system during monthly preventive maintenance rounds, and any malfunctions will be corrected as quickly as possible. IV. As a means of quality assurance, the Administrator will review monthly preventive maintenance reports as well as work orders to ensure that the call light system is being maintained properly, and any noncompliance will be reported to the Quality Assurance Committee during quarterly meetings.</p>	06/01/2012	

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F9999	<p>STATE FINDINGS</p> <p>3.1-9 PERSONAL PROPERTY</p> <p>(g) The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property.</p> <p>Based on record review and interview, the facility failed to ensure a personal effects/inventory sheet was maintained for 1 of 3 discharged residents whose records were reviewed related to personal effects/inventory sheets from a sample of 17 residents. (Resident #82)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #82 was reviewed on 5/23/12 at 2:45 P.M. Nursing notes dated 4/16/12 indicate the resident was discharged to home. A personal effects/inventory sheet was not found with the Resident #82 records.</p> <p>At the end of the day conference on 5/23/12 at 3:45 P.M., a request for</p>	F9999	<p>I. When facility staff were advised that the survey team could not locate an inventory sheet for resident #82, the Social Services Director contacted the resident who had been discharged 3 weeks ago. The resident's husband confirmed that they had taken all of her belongings when she was discharged from the facility. II. As all discharged residents should have belongings accounted for at the time of discharge, a new system has been implemented to ensure this is accomplished. III. When a resident is discharged, the Social Services Director is responsible to ensure that the inventory sheet is obtained from the chart and signed by the resident/family members. If the discharge is unexpected and the resident/family members are not available to sign the inventory sheet, the Social Services Director will contact them by telephone to verify that they did receive all their belongings, and document their response on the inventory sheet. The inventory sheet will then be mailed to them with an envelope requesting that it be signed and returned to the facility, and a copy maintained in the resident's closed record. IV. The Social Services Director will submit copies of all inventory sheets for discharged residents to the Administrator, who will note</p>	06/15/2012	

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	<p>Resident #82's inventory sheet was made to the Director of Nursing and to the Administrator.</p> <p>At the end of the day conference on 5/24/12 at 4:00 P.M., an additional request for Resident #82's inventory sheet was made to the Director of Nursing and to the Administrator. During interview at that time, the Director of Nursing indicated the inventory sheet was missing.</p> <p>3.1-9(g)</p>		<p>on a log sheet that they have been addressed properly. Any failure to do so will be reported by the Administrator to the Quality Assurance Committee during quarterly meetings.</p>		