STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN VALLEY CARE CENTER	3118 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 29, 30, & 31, 2013. November 1, 4, 5, 6, & 7, 2013. Facility number: 000028 Provider number: 155070 AIM number: 100275370 Survey team: Joan Laux RN/TC Caitlin Lewis RN (10/29, 10/30, 10/31, 11/1, 2013) Paula Davidson RN (10/29, 10/30, 10/31, 11/1, 2013) Gwen Pumphrey RN (10/29, 10/30, 10/31, 11/1, 11/4, 11/5, 11/7, 2013) Gloria Reisert MSW (10/29, 10/30, 11/1, 11/4, 11/5, 11/6, 2013) Census bed type: SNF/NF: 94 Total: 94 Census payor type: Medicare: 5 Medicaid: 84 Other: 5 Total: 94	F000000	Allegation of Compliance Please accept the following plan of correction for the annual survey on October 29th, 2013 – November 7th, 2013. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on November 13, 2013 by Cheryl Fielden RN.			

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F000157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician when blood sugar results fell outside the physician set	F000157	To ensure adequate notification Nursing Administration reviewed Resident #39's blood sugar recordings dating back to October 1, 2013. The physician was notified of any readings found to	12/05/2013

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	parameters of less than 60 [< 60] or greater than 400 [> 400] for 1 of 1 resident reviewed for physician notification in a sample of 6 residents. (Resident #39) Finding includes: Review of the clinical record for Resident #39 on 11/4/13 at 9:47 a.m., indicated the resident had diagnoses which included, but were not limited to: diabetes mellitus. Review of the September 2013 Monthly Physician Orders indicated the resident had an order dated 5/2/12 to "Check and record blood sugar before meals and at bedtime - notify MD [physician] if BS [blood sugars] were < [less than] 60 or > [greater than] 400." Review of the September 2013 Blood Sugar Monitoring Record indicated the resident's blood sugars fell outside the set parameters established by the physician: 9/2 - 48 at 6 a.m. 9/3 - 417 at 4:00 p.m. 9/7 - 410 at 4:00 p.m. 9/8 - 460 at 4:00 p.m. 9/11 - 408 at 4:00 p.m. 9/17 - 407 at 4:00 p.m.		be less than 60 or greater than 400. No new orders were provided. On 11/21/2013 an audit was completed by Nursing Administration dating back to October 1, 2013 of the residents currently residing in the facility with orders for blood sugar checks. The audit was to ensure adequate physician notification of any blood sugars noted to be higher or lower than the physician's pre-ordered parameters. On 11/15/2013 Licensed Nursing staff were re-educated by the Staff Development Coordinator on the importance of ensuring the physician is notified of blood sugar readings found to be higher or lower than the physician's pre-ordered parameters. 4.D.O.N. or designee will audit the blood sugar readings for residents receiving blood sugar checks at least three (3) times per week for (4) weeks and continue weekly for no less than two (2) additional months to ensure that the physician is notified of any blood sugar readings noted to be higher or lower than the physicians pre-ordered parameters. The results of these audits will be presented to the monthly Performance Improvement Committee.The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits.Plan to be	

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	9/18 - 401 at 9:00 p.m. 9/22 - 431 at 4:00 p.m. 9/25 - 55 at 6:00 a.m. 9/26 - 436 at 4:00 p.m. 9/30 - 444 at 4:00 p.m. Review of the October 2013 Blood Sugar Monitoring Record indicated the resident's blood sugars fell outside the set parameters established by the physician: 10/24 - 483 at 4:00 p.m. 10/26 - 440 at 4:00 p.m. Review of the November 2013 Blood Sugar Monitoring Record indicated the resident's blood sugars fell outside the set parameters established by the physician: 11/3 - 436 at 4:00 p.m. 11/5 - 445 at 11:00 a.m. Documentation was lacking of the physician having been notified when the readings fell outside the parameters set by the physician. Review of the Blood Sugar monitoring log for November 2013 on 11/6/13 at 3:40 p.m., the following information was listed in front of the resident's record page: "Medical Director Recommendations Blood Sugar and Blood Pressure parameters. Guideline Statement:		updated as indicated.	

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	Unless otherwise specified by the attending physician, the following recommendations have been approved by the Medical Director and will be administered: Blood Glucose Parameters: 1. Blood Sugars GREATER THAN 400 will be called to the attending physician for follow up;..." During an interview with LPN #1 on 11/6/13 at 4:00 p.m., she indicated that this was the protocol the nurses were to follow unless the primary MD gave different orders. On 11/7/13 at 10:05 a.m., the Director of Nursing presented a copy of the facility's current policy titled: "Changes in resident's Condition or Status". Review of this policy included, but was not limited to: "Policy: The facility will notify...his/her attending physician...of changes in the resident's condition and/or status. Procedure:...1. Nursing services will be responsible for notifying the resident's attending physician when:...d. The is a need to alter the resident's treatment or medications significantly...5. All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with our documentation policies and			

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	procedures..." 3.1-5(a)(3)			

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F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure the Pain Assessments were accurate and the all sections of the Pain	F000272	On 11/21/2013, Res. #8 and Res. # 10 were assessed for any c/o of pain or discomfort. Their pain assessments were reviewed and updated to reflect their current pain status, including the site of	12/05/2013

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	Assessment were complete to determine sites of pain, how the pain might affect daily functioning, frequency and intensity of pain for 2 of 2 residents reviewed for Pain in a sample of 2 residents. (Resident #10 and #8) Findings include: 1. Review of the clinical record for Resident #10 on 11/6/13 at 10:55 a.m., indicated the resident had diagnoses which included, but were not limited to: Alzheimers dementia with behaviors and severe disturbance of mood, osteoarthritis, Parkinsons, history of cerebral vascular accident, and diabetes mellitus. The 10/30/13 Investigative Report, as presented by the Director of Nursing on 11/6/13 at 8:55 a.m., indicated that on 10/27/13, the resident was found to have a 23 centimeter [cm] by 13 cm dissipating yellow with purple discoloration noted to the lateral anterior aspect of the right forearm and elbow area as well as a 10 by 4.5 cm discoloration to the right calf where there is a healing skin tear noted at. The resident was unable to verbalize details or cause. Pain upon palpitation was also noted at this		pain, how it may affect their daily functioning and the frequency and intensity of pain. On 11/21/2013, an audit of pain assessments was completed by Nursing Administration dating back to 10/1/2013 for residents currently residing in the facility, to ensure assessments were accurately reflective of the resident's current pain status. There were no complaints of pain identified during the audit. Assessments were updated as indicated.On 11/15/2013 Licensed Nursing staff were re-educated by the Staff Development Coordinator on the importance of accurately assessing and documenting a resident's pain status for both the cognitively intact and cognitively impaired.4.D.O.N. or designee will randomly audit completed pain assessments on a weekly basis for four (4) weeks and continue weekly for no less than two (2) additional months to ensure that pain assessments are accurately reflecting the resident's current pain status.The results of these audits will be presented to the monthly Performance Improvement Committee.The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits.Plan to be updated as indicated.	

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	time. Review of the 10/27/13 Pain Assessment completed on the day the resident was discovered to have extensive bruising on right arm and leg, indicated the resident currently had no pain and none was reported. The assessment also indicated the resident was at risk for pain, had pain in the past, and was reluctant to express pain. Documentation was lacking on the assessment as to a reason why the resident may be reluctant to verbalize/express pain. During an interview with the Director of Nursing on 11/5/13 at 2:14 p.m., he indicated that due to the resident's poor cognitive status, her response of being pain fluctuated from being in pain to saying she was not in pain. Under the comments section of the assessment, it indicated that PRN [as needed] Tylenol was given for complaints of right elbow pain. The 10/9/13 Annual Minimum Data Set [MDS] Assessment indicated the resident scored a 3 on the BIMS [Brief Interview Mental Status] test which indicated she was severely cognitively impaired.			

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	Review of the clinical record indicated the resident also indicated the resident currently had a care plan which addressed that the resident was prone to skin tears due to fragile skin and was at risk for pain due to osteoarthritis and osteoporosis. 2. Review of the clinical record for Resident #8 on 11/1/13 at 2:30 p.m., indicated the resident had diagnoses which included, but were not limited to: arthritis, anxiety, depression, and peripheral vascular disease. During an interview with Resident #8 on 10/29/13 at 12:22 p.m., she indicated she was hurting all over from the crippling arthritis. Review of the 3/7/13, 5/23/13 and 8/15/13 Pain Assessments indicated the resident was currently in pain, was at risk for pain, and experienced pain in the past. The assessments failed to document whether the pain interfered with daily living in the past 24 hours even though the assessments indicated the resident was currently in pain when assessed; what made the pain worse, how much relief pain treatments/medications provided, and failed to document the site/location of the pain, intensity on best day, average day and worst day			

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	and failed to list non-medication and medication used in relieving the pain. Review of the nursing notes between August 1 and November 1, 2013 indicated the resident had no complaints of pain until 10/30/13 when she informed the nurses of routine Tylenol no longer effective and a new order was received. During an interview with LPN # on 11/4/13 at 10:15 a.m., she indicated "She had routine Tylenol and for the most part, it was effective until last week when she said something to her friend when visiting, of how she was now hurting. We got a new order for her. She also had a habit of refusing all of her meds for some reason including her pain medications. We and the MD [physician] spoke with her that if she didn't at least take her pain meds, then she would hurt. She is now taking all of her meds." 3.1-31(a) 3.1-31(c)(1) 3.1-31(c)(2) 3.1-31(c)(3) 3.1-31(c)(4) 3.1-31(c)(13)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview, the facility failed to follow a physician's order to be notified when the resident's blood sugar results fell outside the set parameters of less than 60 or greater than 400. This deficient practice affected 1 of 1 resident reviewed for blood sugar monitoring in a sample of 6 residents. (Resident #39) Finding included: Review of the clinical record for Resident #39 on 11/4/13 at 9:47 a.m., indicated the resident had diagnoses which included, but were not limited to: diabetes mellitus. Review of the September 2013 Monthly Physician Orders indicated the resident had an order dated 5/2/12 to "Check and record blood sugar before meals and at bedtime - notify MD [physician] if BS [blood sugars] were < [less than] 60 or > [greater than] 400." Review of the September 2013 Blood	F000282	To ensure adequate notification, Nursing Administration reviewed Resident #39's blood sugar recordings dating back to October 1, 2013. The physician was notified of any readings found to be less than 60 or greater than 400. No new orders were provided. On 11/20/2013 an audit was completed by Nursing Administration dating back to October 1, 2013 of the residents currently residing in the facility with orders for blood sugar checks. The audit was to ensure adequate physician notification of blood sugars noted to be higher or lower than the physician's pre-ordered parameters. The physician was notified of any readings found to be less than 60 or greater than 400. No new orders were vided.	12/05/2013

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	Sugar Monitoring Record indicated the resident's blood sugars fell outside the set parameters established by the physician and had no physician notification: 9/2 - 48 at 6 a.m. 9/3 - 417 at 4:00 p.m. 9/7 - 410 at 4:00 p.m. 9/8 - 460 at 4:00 p.m. 9/11 - 408 at 4:00 p.m. 9/17 - 407 at 4:00 p.m. 9/18 - 401 at 9:00 p.m. 9/22 - 431 at 4:00 p.m. 9/25 - 55 at 6:00 a.m. 9/26 - 436 at 4:00 p.m. 9/30 - 444 at 4:00 p.m. Review of the October 2013 Blood Sugar Monitoring Record indicated the resident's blood sugars fell outside the set parameters established by the physician and had no physician notification: 10/24 - 483 at 4:00 p.m. 10/26 - 440 at 4:00 p.m. Review of the November 2013 Blood Sugar Monitoring Record indicated the resident's blood sugars fell outside the set parameters established by the physician and had no physician notification: 11/3 - 436 at 4:00 p.m. 11/5 - 445 at 11:00 a.m.		On 11/15/2013 Licensed Nursing staff were re-educated by the Staff Development Coordinator on the importance of following physician orders and ensuring the physician is notified of blood sugar readings found to be higher or lower than the physician's pre-ordered parameters. The D.O.N. or designee will audit the blood sugar readings for residents receiving blood sugar checks at least three (3) times per week for (4) weeks and continue weekly for no less than two (2) additional months to ensure that the physician is notified of any blood sugar readings noted to be higher or lower than the physicians pre-ordered parameters. The results of these audits will be presented to the monthly Performance Improvement Committee.The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits.Plan to be updated as indicate	

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	Review of the Blood Sugar monitoring log for November 2013 on 11/6/13 at 3:40 p.m., the following information was listed in front of the resident's record page: "Medical Director Recommendations Blood Sugar and Blood Pressure parameters. Guideline Statement: Unless otherwise specified by the attending physician, the following recommendations have been approved by the Medical Director and will be administered: Blood Glucose Parameters: 1. Blood Sugars GREATER THAN 400 will be called to the attending physician for follow up;..." During an interview with LPN #1 on 11/6/13 at 4:00 p.m., she indicated that this was the protocol the nurses were to follow unless the primary MD gave different orders. On 11/7/13 at 10:05 a.m., the Director of Nursing presented a copy of the facility's current policy titled "Glucose Testing". Review of this policy included, but was not limited to: "...Procedure:...22. Record the result in the resident's medical record and follow physician orders for notifying the physician...All interventions are documented in the resident's medical record."			

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	3.1-35(g)(2)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. Based on record review, interview, and observation the facility failed to follow a gradual dose reduction order for Resident #102. This deficient practice affected 1 of 5 Residents reviewed for unnecessary medications. (Resident #102) Findings include: On 11/4/13 at 9:25 a.m., during a review of the Physician's orders dated	F000329	On 11/4/2013 Resident # 102's physician was notified. Orders were received to continue with changing the order for Paxil from 40mg daily to 20mg daily. Additionally, in review of the alleged deficient practice, no harm was incurred by the resident. On 11/15/2013 an audit was completed by Nursing Administration of Pharmacy recommendations dating back to September 1, 2013 to ensure that any pharmacy recommendations for Gradual Dose Reductions had been followed up on and orders	12/05/2013

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	9/26/13, it was indicated that Resident #102 had diagnoses including, but not limited to: Altered mental status, dementia of Alzheimer's type, prostate cancer, mood and behavior disturbances, and congestive heart failure. A Medication Administration Record dated 11/1/13 thru 11/30/13 indicated Resident #102 was currently on the following medications: 1 mg (milligram) Lorazepam by mouth every 6 hours, 40 mg Paroxetine by mouth at bedtime and 175 mg Seroquel by mouth at bedtime. A review of Resident #102's Care Plan dated 7/2/13 indicated this resident was on psychotropic medications including, but not limited to the antidepressant Paxil. Interventions included monitoring for adverse drug reactions, administering medications as ordered, and pharmacy to consult to review medications and make gradual dose reduction recommendations. On 11/4/13 at 9:43 a.m., Resident #102 was observed sitting in his wheelchair on the 400 Hall/Alzheimer's unit. He requested a cup of coffee. A staff member responded immediately and went to		obtained as indicated. No findings were noted. On 11/15/2013 Licensed Nursing Staff and Social Services were re-educated by the Staff Development Coordinator on the importance of following up on Pharmacy Recommendations and ensuring that orders for Gradual Dosage Reductions are processed.The D.O.N. or designee will audit orders for Gradual Dose Reductions on a weekly basis for 4 weeks and continue weekly for no less than two (2) additional months to ensure Gradual Dose Reductions are completed as ordered.D.O.N. or designee will audit Pharmacy Recommendations on a monthly basis for three (3) months and continue monthly for no less than two (2) additional months, to ensure that the Pharmacy Recommendations have been adequately followed up on and orders obtained as indicated. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	get the coffee. During a review of the Pharmacy Consultation form on 11/4/13 at 2:20 p.m. dated 10/30/13, it indicated a recommendation of lowering Paxil 40 mg (milligram) by mouth every day to 20 mg by mouth every day. Resident #102's Physician accepted the recommendation by checking the area on the Pharmacy Consultation form which reads: "I accept the recommendation above, please implement as written." During an interview with LPN (Licensed Practical Nurse) #3 on 11/4/13 at 2:55 p.m., he indicated "I have not heard of anyone lowering the amount of Paxil. I've been here for 4 months and it's never been lowered. I think they have to try to do that every 6 months." A review of the MAR (Medication Administration Record) on 11/4/13 at 3:00 p.m., dated 11/1/13 through 11/30/13 indicated Paxil 40 mg was being given daily at bedtime. Paxil had been given on 11/1, 11/2, and 11/3, 2013. During an interview with the DON on 11/4/13 at 3:12 p.m., he indicated he was unable to locate a Physician			

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	order to support the GDR (gradual dose reduction) on lowered Paxil from 40 mg daily to 20 mg daily. During an interview with the DON on 11/5/13 at 8:30 a.m., he indicated the facility had changed the error that was found on the Paxil. The facility followed the GDR recommendation and Physician approval of such recommendation by lowering the dose of Paxil from 40 mg to 20 mg daily. He further indicated that the facility was starting a complete chart audit of all pharmacy recommendations today to ensure no more errors. During a review of the MAR at 8:30 a.m. dated 11/4/13, Paxil 20 mg every day at 8 p.m. was indicated. During a review at 8:35 a.m. of a Physician order dated 11/4/13, it indicated to discontinue Paroxetine (Paxil) 40 mg. Start Paroxetine 20 mg every day. On 11/5/13 at 8:45 a.m., a review of the Drug Regimen Review Policy and Procedure indicated "Notation of irregularities and/or potential problems shall be submitted by the consultant...to the attending physician and the director of nursing			

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	services...the nurse and/or the physician must read the findings of the consultant pharmacist and respond in writing." A review of the Drug Regimen Review Responses Policy and Procedure indicated "Once a physician has documented his/her response to a drug regimen review comment and signed the comment, the facility nurse is responsible for faxing it directly to the pharmacy." During an interview on 11/6/13 at 2:00 p.m., the DON indicated "I would expect that GDR to be followed up on and the order written to reflect the Physician ' s orders." During a review of the Physician's Orders Policy and Procedure on 11/7/13 at 10:05 a.m., the Policy and Procedure indicated "Proper channels of communication are used to ensure accurate delivery of medications and treatments to all residents...each time licensed nurse charts in the resident record, the physician orders section should be checked." 3.1-48(a) (1)			

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F000371 SS=F	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 observation, record review and interview, the facility failed to follow proper handwashing, cover facial hair, and ensure equipment was in good working order and free of dust and food particles during 2 of 2 kitchen observations. This deficient practice had the potential to affect 94 of 94 currently residing in the facility. Findings included: 1. During the initial kitchen observation on 10/29/13 between 9:17 a.m. and 9:45 a.m., the following was observed: a. 4 of 11 newly washed steam table pans were observed in the drying rack, which upon inspection food substance on them. An interview with Dietary Aide #1 at this time indicated "Another aide was helping out doing the cook's dishes and she tried hard but guess she didn't get it all out." b. 3 of 3 square ceiling vents (2	F000371	On 10/29/13, maintenance cleaned and repainted the ceiling vents and the light cover was replaced.On 11/5/13, the area on the wall next to the stove the ceiling above the entrance to dry storage room was cleaned, and ceiling lights were cleaned. Steam table pans were re-cleaned and inspected to ensure they were free of food substances. Dietary staff noted with slight facial hair were cleanly shaved. Residents being served meals at the time of alleged deficient practice are at risk to be affected.The Executive Director in-serviced maintenance staff on routine cleaning of kitchen vents and ceiling lights.The Dietary Manager provided re-education to the dietary staff on 11/12/2013 regarding assigned cleaning schedules, required use of beard covers for associates with facial hair, and proper hand sanitation when preparing and serving meals to residents.The Dietary Manager or designee will randomly audit hand sanitation of the dietary staff during the preparation and serving of resident meals at least eight (5)	12/05/2013

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	above washing area and drying racks containing clean steam table pans and 1 above mixer) with dark greasy dust surrounding and on the vents and walls. Loose dust around the vents was observed swaying in the breeze. A big circular air vent in this area had light gray dust around it. The center of vent had a mold-like substance on it. c. 1 of 2 fluorescent light covers above stove area was cracked. d. The big circular air vent above hot plate machine and prep counter with the can opener had dust surrounding the vent and on the 2 light covers in front of the vent. e. Multiple brown splatters on the ceiling above the entrance to the dry storage room - the dish machine prep area was also noted to the right of the door to the dry storage. f. The right side and back wall next to the stove had multiple reddish-brown splatters with dried food particles on it. g. Dietary Aide #2 was observed to have facial hair not covered with any type of protection. The dietary aide was observed putting supplies away		times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	and preparing food trays for the residents who wish to eat in their rooms. All identified areas of concern were discussed with the Dietary Manager at 9:50 a.m. 2. During a kitchen observation on 11/5/13 between 11:30 a.m. and 12:45 p.m., the following was observed: a. The same areas of dust and splatters observed on 10/29/13 at 9:17 a.m., were again observed. b. Dietary Aide #2 was observed to have no facial covering over his facial hair, putting covers over food plates, placing condiments, drinks and desserts onto resident room trays. c. Cook #1 was observed without covering of facial hair - cooking and dipping up lunch meal onto plates for resident room trays moving between the stove and ovens and the steam tables. d. Dietary Aides #1 and #2 observed on numerous occasions to scratch/rub their head and nose on several occasions without washing hands before returning to scoop up			

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	ice into bins, wheeling trays of milk, juice out to dining room. Dietary Aide #2 also answered the phone and then resumed putting condiments and desserts on trays and lids onto foods. On 11/6/13 at 9:00 a.m., the Dietary Manager presented the following items: 1. A copy of the "Weekly Cleaning Schedule" which indicated the walls of the kitchen were to be wiped down throughout the kitchen weekly. 2. A copy of the facility's current policy titled "Cleaning Schedule" which included, but was not limited to: "Guidelines:...The Director of Food and Nutrition Services monitors the cleaning schedule to ensure the tasks are completed timely and appropriately." 3. A copy of the facility's current policy titled "Dietary Services" which included, but was not limited to: "...Personal Hygiene: Proper attire for food handlers should include a hair covering (hairnet or caps),... Moustaches and sideburns must be kept trimmed. Beards must be covered...Adequate numbers of handwashing sinks with soap dispensers and single-use towels are provided. Wash hands carefully with			

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	soap and water whenever they become soiled:..after touching hair, mouth,...and before touching food, clean dishes, and silverware..." 3.1-21(i)(3)			

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. 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. Based on observation, interview and record review, the facility failed to ensure medications were properly	F000431	Upon review of the alleged incident as cited in the Summary Statement of Deficiencies, no harm was incurred by residents # 4, #56 or #103 related to the	12/05/2013

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	stored and labeled. This deficient practice was based on observation of storage areas on 3 of 4 units in the facility. This deficient practice affected 3 residents currently residing in the facility.(Resident # 4, 56, and 103) Findings include: 1. On 11/5/13 at 11:31a.m., the medication storage area on the 500 unit was observed to have the following: -3 Juven packs .85 oz, used for therapeutic nutrition, lacked label of resident name and physician order, -27 packages of polyethylene glycol 3550 17 gm lacked label of resident name and physician order -Promod, wound healing supplement, for Resident #56 opened on 10/12/13 with an expiration date of 11/01/13. -1 container of Nutrisource fiber was found in the medication storage room with an expiration date of 7/28/13 The clinical record was reviewed on 11/05/13 at 2:30p.m., indicated Resident #56 had diagnoses including but not limited to, Alzheimer's disease, dementia, hypertension(high blood pressure),constipation, and		alleged deficient practice. Nursing administration ensured that all medication carts locked and residents # 4, #56, and #103 medications were labeled and stored properly. All current residents have the ability to be affected by the alleged deficient practice. An audit was completed on 11/7/2013 by Nursing Administration to ensure that medications including house stock were not expired, stored properly, and accurately labeled as indicated. On November 15, 2013, Licensed Nursing Staff were re-educated on the importance of ensuring that medications are not expired, stored properly, and accurately labeled as indicated. The D.O.N. or designee will audit medication carts, and medications, including house stock three (3) times a week for four (4) weeks and continue weekly for no less than two (2) additional months to ensure that medications are not expired, stored properly and accurately labeled as indicated. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	hyperlipidemia(high cholesterol. Resident # 56 had a physician's order dated 9/14/13 for Promod 30 ml(milliliters) by mouth twice a day. Review of the Medication Administration Record (MAR) indicated Resident #56 received Promod twice a day on 11/01, 11/02, and 11/03. LPN #5 was interviewed on 11/05/13 at 11:48a.m. LPN#5 indicated medications should be labled from the pharmacy. LPN#5 was not able to identify who the 3 Juven packs or the 27 packs of polyethylene glycol belonged to. LPN#5 confirmed the Promod was expired and removed the supplement from the medication cart. LPN # 5 indicated the nurses are responsible for ensuring medications on the cart are properly labeled and stored. 2. The medication storage areas on the 400 Unit was observed on 11/04/13 at 1:50p.m., to have the following: -Promod, supplement for wound healing, belonging to Resident # 103 with an opened date of 10/2/2013 and expiration date of 8/1/2013. In an interview RN #1 indicated			

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	Resident #103 receives the medication daily. RN #1 indicated Promod was house stock. On 11/04/13 at 2:30p.m., Residents #103 clinical record was reviewed. Resident #103 had diagnoses including but not limited to, dementia with behaviors, alzheimer's, hypertension(high blood pressure), diabetes, and depression. A physician's order dated 10/7/13 indicated, " Promod 30 cc orally two times a day to promote wound healing for 30 days". Review of the Medication Administration Record (MAR) for October 2013 and November 2013 indicated Resident #103 received Promod as ordered on 10/7/13 thru 11/04/13. 3. On 11/05/13 at 9:12a.m. the medication storage room on the 300 Unit was observed to have 3 containers of beneprotein powder that were expired 10/17/2013. LPN #6 indicated in 11/05/13 at 9:15a.m., no resident on the unit was prescribed the beneprotein powder. LPN#6 indicated the beneprotein powder was house stock and disposed of the 3 containers. 4. On 11/05/2013 at 12:01p.m., the			

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	600 Unit was observed to have the following: -1 can of beneprotein powder with an expiration date of 10/19/13. -1 bottle of Pro Stat Sugar 64 Free Complete Protein Supplement with an expiration date of 7/2013. In an interview LPN #2 indicated the beneprotein powder belonged to Resident #4. LPN #2 indicated, "She did not get it today." Resident #4's clinical record was reviewed on 11/07/13 at 1:00p.m., indicated she had diagnoses including but not limited to, cerebral palsy, psychosis, osteoporosis, and urinary incontinence. The Medication Administration Record (MAR) indicated she received, Benefiber powder 4 gm every 12 hours twice a day. Resident#4 received the supplement on 10/01/13 thru 11/05/13. 5. On 11/07/13 at 4:11p.m., the medication cart on the 400 Unit was observed to be unlocked and unattended. LPN # 4 indicated in an interview on 11/07/13 at 4:18p.m., "That's my fault because me and [Assistant Director of Nursing] was looking in			

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	it[medication cart]." Then LPN #4 locked the medication cart. Review of the policy and procedure titled, "Medication Storage" was received from the Director of Nursing on 11/06/13 at 9:00a.m., This policy indicated, "medications must be kept under continuous supervision". The policy lacked documentation related to disposal of expired medications. 3.1-25(m) 3.1-25(o)			

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and	F000441	Upon review of the alleged incident as cited in the Summary	12/05/2013

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	record review the facility failed to ensure glucometers were properly cleaned between use. This deficient practice affected 2 of 2 residents observed for blood glucose monitoring. (Resident # 67 and 107). Findings Include: 1. During an observation on 11/07/13 at 4:15, LPN #4 was observed cleaning the glucometer before use on Resident #67. In an interview on 11/07/13 at 4:15p.m., LPN #4 indicated she was using an alchohol prep wipe to clean the glucometer. 2. After obtaining Resident #67's blood glucose, LPN#4 cleaned the glucometer with another alcohol prep wipe. During an observation on 11/07/13 at 4:45p.m., LPN #7 removed the same glucometer used by LPN#4 from the medication cart. LPN#7 did not clean the glucometer before use. After obtaining Resident #107's blood glucose, LPN#7 cleaned the glucometer bare handed with a Sani Cloth wipe in the hallway of the unit. 3. LPN #5 indicated in an interview		Statement of Deficiencies, no harm was incurred by residents #67 and #107 related to the alleged deficient practice. On 11/15/2013 and 11/25/2013 LPN's # 4 and #7 were re-inserviced with return demonstration on the correct method of cleaning glucometers according to facility policy.Residents receiving blood sugar checks via a glucometer at the time of the alleged deficient practice are at risk to be affected. On 11/15/2013 Licensed Nursing staff were provided re-education with return demonstration by the Staff Development Coordinator on the correct method of cleaning glucometers according to facility policy. The D.O.N. or designee will randomly audit nursing staff obtaining blood sugar readings at least three (3) times per week for four (4) weeks and continue weekly for no less than two (2) additional months to ensure that glucometers are being cleaned according to company policy. The results of these audits will be presented to the monthly Performance Improvement Committee.The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits.Plan to be updated as indicated.	

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	on 11/05/13 at 11:48a.m., "we use the wipes [Sani-cloth wipes] after every use". LPN #6 indicated in an interview on 11/05/13 at 1:50p.m., RN#1 indicated in an interview on 11/05/13 at, " We use the sani wipes before and after use." A copy of the policy titled "Cleaning and Disinfection of the Glucometer" was obtained from the Director of Nursing on 11/07/13 at 5:43p.m. The policy indicated , "the glucometer was to be cleaned with a Super Sani Cloth or Sani-Cloth Plus after a glucometer check before leaving the room." The policy lacked documentation related to cleaning the glucometer before use. 3.1-18(b)(1)A 3.1-18(3)			