

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
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F000000	<p>This visit was for the Recertification, State Licensure Survey, and State Residential Licensure Survey. This visit included the Investigation of Complaint IN00142128.</p> <p>Complaint IN00142128-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: February 17, 18, 19, 20, 21 and 24, 2014</p> <p>Facility number: 001120 Provider number: 155758 AIM number: 200525120</p> <p>Survey team: Teresa Buske RN-TC February 17, 18, 19, 20, and 24, 2014 Mary Weyls RN Laura Brashear RN</p> <p>Census bed type: SNF 19 SNF/NF 20 Residential 57 Total 96</p> <p>Census payor type: Medicare 4 Medicaid 15 Other 77</p>	F000000		

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

TITLE

(X6) DATE

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

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	<p>Total 96</p> <p>Residential sample 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 02/27/2014 by Brenda Marshall, RN.</p>				

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure confidentiality of personal clinical information for 1 of 1 random observation in that Resident #25's medical condition was discussed in front of a maintenance staff member.</p>	F000164	F 164 SS=D Personal Privacy/confidentiality of RecordsDeficiency: Two LPN's were discussing a resident's medical condition in front of maintenance staff. RESPONSE: A nursing in service was held on 01/02/14 in which one of the topics was HIPPA and confidentiality. (See Exhibit O). A	03/17/2014

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	<p>Finding includes:</p> <p>On 2/19/14 at 11:20 a.m. LPN #1 and LPN #2 were observed at the nursing station. The staff members were discussing a recent onset of a medical condition of Resident #25. After the initial discussion LPN #2 called the physician regarding the matter as the maintenance staff went down the hall. Within a few minutes the two LPNs and the maintenance staff member returned to the desk and the LPNs continued the discussion.</p> <p>On 2/24/14 at 2:03 p.m. the DON was interviewed. The DON indicated staff have been instructed several times to be careful when speaking about residents' care in front of others.</p> <p>A policy titled "Resident Rights," (no date), provided by the Assistant Director of Nursing on 2/24/14 at 3:25 p.m., did not include maintaining confidentiality of residents' medical information.</p> <p>3.1-3(o)</p>		<p>follow-up message on this subject was sent via the On-Shift messaging system to all Nursing employees on 01/04/14. (See Exhibit P). It is unfortunate that this incident occurred, especially given the very recent education. All nursing staff including individuals involved in the deficient practice were coached during 02/24/14 in-service (Exhibit Q) on the appropriate procedure to share information without violating the HIPPA privacy act. The Director of Nursing reviewed the policy and procedure for training the staff on HIPPA privacy practices. New hires have been verbally made aware of the HIPPA policy in orientation and it is a scheduled in-service on Silverchair to be completed within six months of employment. Effective 03/11/14 all newly hired employees will be provided a copy of the "HIPPA policy" (Exhibit S) along with discussion of the policy with the Human Resource Director to assure understanding. . As a refresher, a copy of the "HIPPA Policy" will be given to each staff member with their pay check dated March 14, 2014. A brief explanation of the deficiency and a sign off sheet showing the employee received the "HIPPA Policy" will be put in the staff members file. HIPPA in-services are included in the Silverchair Learning system semi-annually. Another review will be conducted</p>	

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interviews, and record review the facility failed to ensure it was free from medication error rates of 5 percent or greater in that 4 errors in the opportunity for 32 errors were observed which resulted in a 12.5 percent error rate. (Residents #24, #41, and #44)</p> <p>Findings include:</p> <p>1. On 2/24/14 at 11:31 a.m. LPN #1 was observed to administer a</p>	F000332	<p>during nursing in-service on 03/17/2014. Monitoring is ongoing by Supervisors and the Human Resource Director to ensure their staff members are keeping current on their in-services. Also the HIPPA Committee members will monitor conversations at nurses' stations monthly to confirm continued compliance or respond to inappropriate information exchanges should they occur. Monitoring episodes will be recorded on paper and appropriate follow-up will be conducted if needed. As additional proof of the the HIPPA committee's attention to privacy issues. please see Exhibit T.</p> <p>F332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE(1.) Deficiency: On 02/24/14 LPN was preparing to give resident Novolog insulin that was marked "Do not use after 02/19/14". RESPONSE: No residents were harmed by the deficient practice. Upon discovery of the deficient practice medication carts were inspected to ensure no other medications were outdated. Staff members involved were immediately re-educated in the correct expiration date for insulin. See Exhibit R. Nursing staff will</p>	03/17/2014	

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	<p>medication to resident #41. The resident was to receive Novolog Insulin 3 units for coverage of a glucose reading of 248. The nurse removed a vial of Novolog from the medication cart, for Resident #41. A sticker on the vial was noted of "Do not use after 2/19/14. January 22, 2014 was noted on the vial of date opened. The nurse began to prepare the injection. When questioned about the expiration date the nurse indicated she thought the insulin was good for use for two months after date opened. At that time, the DON was consulted and indicated the facility policy was insulin good for use 30 days after date opened.</p> <p>The resident's February 2014 recapitulation of physician's orders included, but was not limited to, "812/13 Novolog 100 unit/ml (milliliter) inject sub-q (subcutaneously) per sliding scale-type 2 DM (diabetes mellitus,) 241-320=3 units." A physician's order written and signed by the physician on 2/21/14 was noted to continue accu check coverage.</p> <p>The facility policy titled "Recommended Minimum Medication Storage Parameters</p>		<p>be in-serviced on March 17, 2014 on the recommended insulin and medications storage parameters. See Exhibit B. As an additional resource, the Omnicare Insulin Storage recommendations and the Recommended Minimum Medication Storage Parameters were placed in the Medication Administration Record (MAR) for easy access. See Exhibit C. Omnicare also comes in to do a medication cart review monthly. On March 7, 2014 Omnicare was here to do medication cart reviews. Monitoring will be ongoing quarterly by the Director of Nursing or designee. Deficiency: Medications were not available for the residents. RESPONSE: The pharmacy was called immediately to supply the missing medications. A review of the med carts and orders was completed on 02/24/14 to ensure we were not missing any medications for other residents. A Medication Management guideline sheet was posted at all the nursing stations to provide a reminder of the proper procedures for ordering medications. See Exhibit D. An in-service will be provided to all nursing staff 03/17/14 on the procedures for ordering medications and the importance of following through on any orders that have not been received in a timely manner. A Medication Management Quality Assurance Checklist was created as a</p>				

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	<p>(Based on Manufacturer Package Inserts), dated 2005, provided by the DON on 2/24/14 at 2:49 p.m. for "Insulin Products (all vials) the following information was provided. "BASED ON AMERICAN DIABETES ASSOCIATION GUIDELINES, ALL UNOPENED INSULINS ARE RECOMMENDED TO BE STORED IN THE REFRIGERATOR. ALL PRODUCT SHOULD BE DISCARDED 28 DAYS AFTER OPENING."</p> <p>2. On 2/24/14 at 12:15 p.m. with LPN #1 the nurse prepared medications for Resident #44. The nurse indicated the resident was to receive Delzicol DR (for Chron's Disease) 400 mg four times a day. The nurse indicated she did not have the medication and the 8:00 a.m. dose was not available as well as the noon dose.</p> <p>The recapitulation of physician's orders, for February 2014, signed by the physician on 2/5/14, reviewed on 2/14/14 at 5:08 p.m. included, but not limited to, "12/26/13 Delzicol DR 400 mg capsule. Give 1 capsule orally 4 times a day for Crohns Disease. The scheduled times were 9:00 a.m. 12:00 p.m., 5:00 p.m. and 8:00 p.m.</p>		<p>monitoring tool for the Director of Nursing or her designee. See Exhibit E. This will be completed quarterly and the results presented and discussed at the quarterly Continuous Quality Improvement Council meeting along with the results of the medication cart audits performed by Omnicare. Monitoring will be ongoing by the Director of Nursing or designee.</p> <p>(4.)Deficiency: After administering Advair, LPN did not have resident rinse mouth and spit. RESPONSE: The resident was not harmed by the deficient practice.The nurse was immediately re-educated to follow the instructions on the proper administration of the medication. An in-service for all nursing staff is scheduled for March 17, 2014 on the proper use of inhalers and will be repeated annually. See Exhibit F. Monitoring will be ongoing by the Director of Nursing or designee. As proof of previous education on this topic, a copy of the On Shift educational reminder from January 7, 2014 has been included as Exhibit Q.</p>				

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	<p>On 2/24/14 at 2:48 p.m. the DON provided a copy of a facsimile sent to the resident's mail order medication supplier, of a physician's order sent on 1/13/14. At that time the DON indicated the local pharmacy had been notified to send a week's worth of the medication would be received today. The nurse indicated the facility is to obtain the medications from the local pharmacy if mail orders are not available for the resident.</p> <p>3. On 2/24/14 at 1:35 p.m. LPN #1 was observed administering medications to Resident #44. The nurse indicated the resident was to receive the anti-depressant Wellbutrin SR 150 mg. The nurse indicated the medication was not available and documentation on the administration record indicated had not been available on February 22 and 23, 2014.</p> <p>The resident's clinical record was reviewed on 2/24/14 at 2:47 p.m. A physician's order, written by the physician on 2/21/14, was noted for "Wellbutrin SR 150 mg po (by mouth) every noon for depression."</p> <p>On 2/24/14 at 2:47 p.m. the DON</p>			

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	<p>indicated the order had been faxed to the pharmacy and they don't know why it was not sent.</p> <p>4. On 2/24/14 at 1:50 p.m. LPN #1 was observed administering the inhalant medication Advair for copd chronic obstructive pulmonary disease to Resident #24. The resident inhaled the medication. Documentation on the pharmacy label of the medication was noted to rinse mouth and spit out after inhalation.</p> <p>The resident's February 2014 recapitulation of physician's orders, signed by the physician on 2/5/14, included but was not limited to, "6/06/13 Advair 250-50 Diskus Inhale 1 Disk W/DEV (with device) orally 2 times a day-COPD".</p> <p>Documentation from the web site: ("approved by the U.S. Food and Drug Administration," "us.gsk.com/products/assets/us_advair.pdf", January 2011, included, but was not limited to, After inhalation, the patient should rinse the mouth with water without swallowing...."</p> <p>3.1-25(b)(9)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to store frozen food items in sealed, labeled packaging for 1 of 1 dietary observation. This deficient practice had the potential to affect all residents of the facility.</p> <p>Finding includes:</p> <p>On dietary tour with the Food Service Supervisor (FSS) on 2/17/14 at 11:45 a.m., the following was observed:</p> <p>a. Reach in freezer #2 contained one brown paper bag of hash brown potatoes torn and food exposed. One bag of fish fillets containing about 10 pieces was opened and not sealed. A package of chicken drumittes was opened and not sealed. A package of chicken patties was open and not sealed and one bag of fish fillets containing 15-20 fillets was opened and not sealed. The FSS indicated the freezer was</p>	F000371	F 371 SS=F 483.35(i) FOOD PROCURE/STORE/PREPARE/SERVE SANITARY Deficiency: An open bag of hash browns, fish fillets and chicken drummies were observed in freezer open with food exposed. Also two boxes of fish patties were sitting on the floor. RESPONSE: No Resident was harmed by the deficient practice. Food Service Director immediately (02/19/14) in-serviced staff members on correct procedures for storing, labeling, dating and wrapping food. See Exhibit M. Staff was instructed that once a bag of frozen food has been opened it either needs to be put in an air-tight container or a zip-lock freezer bag and dated. The freezer and reach-in coolers were inspected on 02/17/14 to ensure all items were stored, labeled and dated correctly. The Food Service Director created visual guides on 02/18/14 to be placed in a conspicuous spot on the freezer and walk-in showing the correct storage procedures. See Exhibit K, L. A Refrigeration Stock Control Log was also created and posted on the freezer on	03/10/2014

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	<p>kind of where people "grab and go." The supervisor indicated the packaging should have been sealed.</p> <p>b. The walk in freezer was observed with two boxes of frozen fish patties were sitting on the floor. The FSS indicated "they know better than that."</p> <p>A facility policy titled "Standard Operating Policy & Procedure Subject: Storage-Refrigerator and Freezer," (no date) provided by the FSS on 2/18/14 at 10:34 a.m. included, but was not limited to, "...11. Food in a walk-in refrigerator or freezer must be stored at least 6" (inches) above the floor. 22. All frozen food is dated, labeled, and wrapped. Moisture proof, tight fitting materials are used to prevent freezer burn."</p> <p>3.1-21(h)(3)</p>		03/10/14. See Exhibit N. The cooks are responsible for checking the contents of the freezer at the end of each shift and initialing the log verifying the contents are stored properly. This will be monitored ongoing by the Food Service Director or designee. A complete audit of the kitchen is performed by the Food Service Director twice-monthly to include the Control Log. Results will be included in quarterly CQI report.		

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F000441 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, interview, and record review, the facility failed</p>	F000441	F 441 SS=D INFECTION CONTROL, PREVENT SPREAD,	03/17/2014	

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	<p>to ensure proper sanitation of an accucheck machine to prevent cross contamination for 1 of 2 random observations of blood glucose testing.</p> <p>Finding includes:</p> <p>On 2/24/14 at 11:00 a.m. QMA (Qualified Medication Aide) #3 was observed to perform an accucheck for Resident #37. After performing the test the QMA wiped the glucose meter with a "Dispatch" (hospital cleaner disinfectant towel with bleach). The QMA immediately dried the meter with a paper towel and returned it to the storage case.</p> <p>On 2/24/14 at 5:11 p.m. the DON provided a policy titled "Cleaning and Disinfection of Environmental Surfaces," dated August 2010 which included a section from Medline Industries "the disinfecting guidelines to disinfect your monitor, clean the meter surface with Dispatch Hospital Cleaner Disinfectant Towels with Bleach." The DON at that time indicated the directions on the package should be followed.</p> <p>The Manufacturer's directions on the packaging, reviewed on 2/24/14 at</p>		<p>LINENS QMA performed an accucheck on a resident, disinfected the glucose meter and failed to let it stand for one minute before returning it to its case. RESPONSE: No resident was harmed by this deficient practice. Staff was immediately educated (02/24/14) on the proper procedure for disinfecting the glucose meter. An in-service has been scheduled for March 17, 2014 for all nursing staff. The Director of Nursing will review the manual and instructions for cleaning the Even Care 2 Glucose Meter during this in-service. Training on the proper procedure for cleaning and disinfecting the glucose meter will be included in the initial orientation of nursing staff responsible for taking blood sugar readings. In-services will be repeated annually for a refresher. (See Exhibits H, I and J.) Monitoring/Observation will occur monthly by the Director of Nursing or designee and will be recorded on a Monitoring Log Form, with corrective action being noted (when applicable)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
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	11:00 a.m., included, but were not limited to, "Wipe surface with towel until completely wet. Let stand for one minute." 3.1-18(l)			