

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 14, 15, 18, 19, 20, 21, and 22, 2013</p> <p>Facility number: 001144 Provider number: 155668 AIM number: 200256980</p> <p>Survey team: Gloria J. Reisert MSW, TC Diana Sidell RN Debbie Peyton RN Gwen Pumphrey RN Jill Ross RN (2/18 and 2/20/13) Gordon Tyree RN (2/14, 2/15, 2/18, 2/21, 2/22/13)</p> <p>Census bed type: SNF: 51 SNF/NF: 58 Residential: 10 Total: 119</p> <p>Census payor type: Medicare: 25 Medicaid: 41 Other: 53 Total: 119</p> <p>Residential Sample: 5</p>	F0000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on March 5, 2013, by Cheryl Fielden RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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	
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan which addressed the monitoring of, weight and activity for a resident with a shunt for Normal Pressure Hydrocephalus. This deficient practice affected 1 of 1 resident reviewed for a newly placed brain shunt. (Resident #57)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #57 on 2/19/13 at 8:37 a.m. indicated the resident was admitted to</p>	F0279	This plan of correction constitutes Providence Retirement Home's credible allegation of compliance for the cited deficiency. Nothing in the plan of correction should be construed as admission by the facility of any violation of state and federal statues, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during the annual survey.1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Unable to correct for resident #57 due to	03/20/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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			
	<p>the facility from the hospital on 12/27/12 with diagnoses of normal pressure hydrocephalus, VPS - Ventriculoperitoneal Shunt placement (Oct 2012) and reprogramming, myelodysplasia, peptic ulcer disease, coronary artery disease, dementia, lumbar stenosis, hypertension, insulin dependent diabetes mellitus, and anemia.</p> <p>12/27/12 Admitting MD orders from hospital and January physician orders indicated the following orders needed to be followed due to the resident's recent placement of a shunt due to Normal Pressure Hydrocephalus: - Avoid strenuous activity - Do not lift > 10 #</p> <p>Review of the care plans developed since the resident's admission on 12/27/12 through 1/14/13, documentation was lacking of a care plan which addressed the shunt placement and restrictions in activities along with the resident's frequent complaints of dizziness, nausea when dizzy, headaches and episodes of visual hallucinations.</p> <p>During an interview with LPN #1 on 2/20/13 at 4:25 p.m., she indicated "because there were restrictions associated with his shunt placement</p>		<p>resident being discharged to home.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;All residents with Hydrocephalus shunts will have their care plan reviewed to verify care plan in place and if they are have any restrictions, that they have been care planned.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Licensed nursing staff will be in-serviced to care plan Hydrocephalus shunts and any restrictions that a resident may have.Director of Nursing/Designee will audit 100% of Hydrocephalus shunts weekly for one month, monthly for two months and then quarterly for the remainder of the year for care planning of Hydrocephalus shunts and restrictions if they are present.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recure,i.e., what quality assurance program will be put in place;Director of Nursing/Designee will audit 100% of Hydrocephalus shunts weekly for one month, monthly for two months and then quarterly for the remainder of the year for care planning of Hydrocephalus shunts and restrictions if they are present. Findings will be reported to the QI committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
	<p>and monitoring needed, there should have been a care plan to address the shunt and the restrictions associated with his recent shunt placement."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(c)(2)(A) 3.1-35(c)(2)(B) 3.1-35(c)(2)(c) 3.1-35(d)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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			
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, interview, and record review, the facility failed to ensure medications were labeled in</p>	F0431	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Residents #172, 62, 108,	03/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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			
	<p>accordance with accepted standards of practice, for 4 of 8 medication carts, 26 of 109 residents. (Residents #172, #63, #108, #184, #178, #117, #, #136, #107, #15, #23, #76, #74, #40, #12, #110, #122, #94, #81, #54, #91, #182, #8, #142, and #6.</p> <p>Findings include:</p> <p>During a medication cart observation, on 2/20/13, at 10:36 a.m., with LPN #3, the medication cart for the 300 hall was observed to contain the following medications that had incomplete labels:</p> <ul style="list-style-type: none"> - For Resident #172; 1 box of Mucinex 600 milligrams (mg) tablets, 1 bottle of 325 mg iron tablets, 1 bottle of adult low strength chewable aspirins, 81 mg, and 1 bottle of regular strength tylenol, 325 mg. All containers had the name, the start date, and under "Directions" was written "See MAR" (Medication Administration Record" and had no other information. - For Resident #63; 1 bottle of 325 mg iron tablets and 1 box of 600 mg Mucinex that had the name, the start date, and "See MAR" under the directions. - For Resident #108, 1 bottle of 100 mg stool softener and 1 bottle of 325 		<p>136, 107, 15, 23, 76, 74, 40, 12, 110, 122, 94, 81, 54, 91, 8, and # 6 over the counter medication has been labeled properly to list their name, physician and directions of the medication if different from the manufacturer labeling. Unable to correct for the following residents: 184, 178, 117, 182 and 142 since these residents have discharged from the facility.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;Director of Nursing/Designee will audit all OTC medications for proper labeling and corrective action taken if needed3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Licensed nursing staff will be in-serviced on labeling OTC drugs to include the resident's name, Physician, and usage directions if different from the manufacturing labeling. An audit of Over the Counter (OTC) medications on medication carts will be audited weekly for one month, monthly for two months and then quarterly for the remainder of the year for proper labeling.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;Director of Nursing/Designee will audit Over</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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			
	<p>mg iron tablets with the name, and "See MAR" on the label.</p> <ul style="list-style-type: none"> - For Resident # 184; 1 bottle of 81 mg aspirin, 1 bottle of 325 mg iron tablets, 1 bottle of 100 mg stool softener, 1 bottle 25 mg diphenhydraminie (allergy medication), with the name and start date only on the label. - For Resident #178; 1 bottle of 325 mg acetaminophen with the name and start date and no other information on the label. - For Resident #117; 1 bottle of 325 mg aspirin and 1 bottle of 325 mg tylenol with the name and start date only on the label. <p>On 2/20/13 at 11:13 a.m., with LPN #2, the medication cart for the 400 hallway was observed to contain the following medications with incomplete labels:</p> <ul style="list-style-type: none"> - For Resident #136; 1 bottle of 81 mg aspirin and 1 bottle of 500 mg extra strength non aspirin pain reliever, with the name and start date only on the label. - For Resident #131; 1 box of 600 mg Mucinex, and 1 bottle 500 mg extra strength non aspirin pain reliever, with the name and start date only on the label. - For Resident #36; 1 bottle 100 mg stool softener, 1 bottle of 81 mg 		<p>the Counter (OTC) medications weekly for one month, monthly for two months and then quarterly for the remainder of the year for proper labeling. Findings will be reported to the QI committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
	<p>aspirin, 1 bottle of 325 mg tylenol, 1 bottle of senna laxative, and 1 bottle of 325 mg iron tables, all with the name and start date and no other information on the label.</p> <p>- For Resident #107; 2 bottles of 25 mg allergy relief (diphenhydramine), with the start date and name on the label and no other information on the label.</p> <p>- For Resident #15; 1 bottle of 81 mg aspirin, 1 bottle of tylenol 325 mg both with the start date and name, and no other information on the label.</p> <p>- For Resident #23, 1 bottle of 100 mg stool softener, 1 bottle of 25 mg diphenhydramine, 1 bottle of 325 mg tylenol, and 1 bottle of 81 mg aspirin with the name and start date only on the label and no other information.</p> <p>- For Resident # 76; 1 bottle 81 mg aspirin, 1 bottle of 325 mg tylenol, 1 bottle of 100 mg stool softener, all with the name and start date on the label and no other information.</p> <p>- For Resident #74; 1 bottle of 325 mg tylenol, 1 bottle of 100 mg stool softener, and 1 box of bisacodyl suppositories, with the name and start date on the label and no other information.</p> <p>- For Resident #40; 1 box of 600 mg Mucinex, 1 bottle 325 mg tylenol, 1 bottle 10 mg loratadine with the name and start date on the label and no</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
--------------------	--	---------------	---	----------------------

	<p>other information.</p> <ul style="list-style-type: none"> - For Resident #12; 1 box of 600 mg Mucinex with the name and start date on the label and no other information. <p>On 2/20/13 at 11:43 a.m., with LPN #2, the medication cart for the 100 hallway was observed to contain the following medications with incomplete labels:</p> <ul style="list-style-type: none"> - For Resident #110; 1 bottle of 81 mg aspirin, 1 bottle of 325 mg iron tablets, 1 bottle of 100 mg stool softener, 1 box of 5 mg bisacodyl tablets, all with the start date and name on the label and no other information. - For Resident #122; 1 bottle of 2 mg anti-diarrheal medication, and 1 box 600 mg Mucinex, with the name and start date and no other information on the label. - For Resident #94; 1 box of 600 mg Mucinex with the name and start date and not other information on the label. - For Resident #81; 1 bottle of 325 mg tylenol, 1 box of 2 mg bisacodyl, 1 bottle of 100 mg stool softener, all with the start date and name and no other information on the label. <p>On 2/20/13 at 11:57 a.m., with LPN #2, the medication cart for the 800 hallway was observed to contain the</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
	<p>following medications with incomplete labels:</p> <ul style="list-style-type: none"> - For Resident #54; 1 bottle of 325 mg iron tablets, 1 bottle of 325 mg tylenol, 1 bottle of 81 mg aspirin with the name and start date on the label and no other information. - For Resident #91; 1 bottle of 100 mg stool softener, 1 bottle of 325 mg iron tablets, and 1 bottle of 325 mg tylenol with the name and start date on the label and no other information. - For Resident #182; 1 bottle of 81 mg aspirin and 1 box 600 mg Mucinex with the resident's name and start date on the label and no other information. - For Resident #8; 1 bottle of 81 mg aspirin with the resident's name and start date, 1 box of 600 mg Mucinex with the physician's name, resident's name, and the start date with no other information on the labels. - For Resident #142; 1 bottle of 325 mg iron tablets with the name and start date, 1 bottle of 100 mg stool softener with the resident's name and start date, and 1 bottle of 325 mg tylenol with no information on the label. - For Resident #6; 1 bottle of 325 mg iron tablets, 1 bottle of extra strength tylenol 500 mg, both with the name and start date and no other information on the label. 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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	
	<p>A policy and procedure for "House supply medication" was provided by the Director of Nurses on 2/21/13 at 3:04 p.m., and identified as their current policy. The policy indicated, but was not limited to, "If permitted by state law the facility and consultant pharmacist will assume responsibility for adopting a list of medications considered as house-supplied items. Procedure...B. House supplied medications must bear the following labeling: 1. Manufacturer and/or repackager's name and address 2. Brand name, when applicable 3. Generic or chemical name(s) and/or combinations 4. Strength 5. Lot Number 6. Expiration Date 7. Use and cautions, if applicable. C. If a medication is not intended for use by multiple residents (i.e. and eye drop or tube of ointment, etc.) the resident's name must appear on the container."</p> <p>3.1-25(j) 3.1-25(k)(1)(2)(3)(4)(5)(6)(7) 3.1-25(o)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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			
F0441 SS=E	<p>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.</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>A. Based on observation, interview, and record review, the facility failed to</p>	F0441	1) What corrective action(s) will be accomplished for those	03/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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	
	<p>ensure their infection control policy related to cleaning the blood glucose meter was followed during 5 of 5 observations. This affected Residents #33 #142, #6, and #54 and had to potential to affect 25 residents who receive blood glucose monitoring.</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure their infection control policies related to hand hygiene and glove use were followed during of observations. This had the potential to affect 119 of 119 residents residing in the facility.</p> <p>Findings include:</p> <p>A. On 2/19/13, at 10:54 a.m., LPN #1 indicated three residents needed blood glucose tests before lunch. LPN #1 was observed taking the blood glucose meter from the top drawer of the medication cart and immediately going to Resident #33's room to test the blood glucose. No sanitation of the glucometer was observed before or after use.</p> <p>On 2/19/13, at 11:05 a.m., LPN #1 was observed taking the blood glucose meter from the top drawer of the medication cart and immediately</p>		<p>residents found to have been affected by the deficient practice;Unable to correct for resident # 33, 142, 6, and 54 for this specific occurrence.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;All residents receiving glucometers checks will be identified and monitoring of these residents receiving proper infection control techniques through audits of demonstration.All residents have the potential to be affected by handwashing. Staff to be in-serviced on handwashing after touching facial area, silverware and drinking cups when in the dining room.3) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Licensed nursing staff will be in-serviced on proper cleaning techniques with glucometer machines.Certified nursing assistants will be in-serviced on sanitizing hands while in the dining room after touching their facial area, resident's utensils or drinking cups.An audit of 10% of residents receiving glucometer checks will be audited weekly for one month, monthly for two months and quarterly for the remainder of the year for proper infection control with cleaning the device.An audit for proper sanitizing of hands in</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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	
	<p>going to Resident #142's room to test the blood glucose. No sanitation of the glucometer was observed before or after use.</p> <p>On 2/19/13, at 11:15 a.m., LPN #1 was observed taking the blood glucose meter from the top drawer of the medication cart to Resident # 6's room to test the blood glucose. No sanitation of the blood glucose meter was observed before or after use.</p> <p>During an observation on 2/19/13, at 3:44 p.m., LPN #4 used a blood glucose meter and obtained a blood glucose specimen from Resident # 54. She was not observed to wash her hands prior to donning gloves before she obtained the blood glucose specimen. After she obtained the blood glucose reading, she washed her hands after she removed her gloves, then cleaned the blood glucose meter with a "sani hands ALC", active ingredient alcohol 65.9%, alcohol wipe for 10 seconds. She laid the glucose meter on top of the medication cart on a tissue, then placed it in a drawer. She then used alcohol gel to cleanse her hands.</p> <p>During an observation on 2/19/13 at 4:00 p.m., LPN #4 checked Resident #33's blood glucose level with the</p>		<p>the dining room will be completed weekly for one month, monthly for two months and then quarterly for the remainder of the year.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;An audit of 10% of residents receiving glucometer checks will be audited weekly for one month, monthly for two months and quarterly for the remainder of the year for proper infection control with cleaning the device. Findings will be reported to the QI committee.An audit of proper sanitizing of hands in the dining room will be completed weekly for one month, monthly for two months and then quarterly for the remainder of the year. Findings will be reported to the QI committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
	<p>same blood glucose meter that was used on Resident #54. LPN #4 cleaned the blood glucose meter with the "sani hands ALC" for approximately 10 seconds, and indicated that is what she cleans the glucose meter with, then she obtained the blood glucose reading. LPN #4 then washed her hands and cleaned the meter again with the "sani hands ALC" for 10 seconds.</p> <p>During an interview, on 2/19/13 at 4:08 p.m., LPN #4 indicated that the glucometer is the only one she has on the cart for the 800 hallway.</p> <p>During an interview, on 2/20/13 at 10:15 a.m., RN #5 indicated the germicidal wipes are in a purple topped tub, that is kept either in the med carts or the nurse's station if there is not enough room on the cart, and are used to clean the glucometers.</p> <p>During an interview on 2/20/13 at 10:36 a.m., LPN #3 indicated she cleans the blood glucose meter with alcohol wipes. She indicated she did not know what the purple topped container (Super Sani-Cloth Germicidal Disposable Wipes) was used for, maybe to clean the wheelchairs.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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			
	<p>On 2/19/13, at 2:52 p.m., an interview with LPN #2 indicated each medication cart had one glucometer. She indicated the blood glucose meter was cleaned by wiping it off with a sani cloth between each use.</p> <p>An interview with LPN #6, on 2/20/13 at 11:50 a.m., indicated the blood glucose meter was cleaned with "the wipes in the purple topped bottle."</p> <p>An interview with LPN #7, on 2/20/13 at 2:52 p.m., indicated the blood glucose meter is cleaned with sani wipes after every use.</p> <p>During an interview with LPN #8, on 2/20/13, at 2:54 p.m. indicated the blood glucose meter is cleaned with sani wipes between each resident use.</p> <p>The plastic container of the "PDI Super Sani-Cloth Germicidal Disposable Wipe" indicated to use the wipe for 2 minutes at room temperature "...in healthcare or other settings in which there is an expected likelihood of soiling on inanimate surfaces/objects with blood or body fluids...."</p> <p>A policy and procedure for "Cleaning</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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			
	<p>of Medical Equipment", with a start date of 9/2009, was provided by RN #5 on 2/20/13, at 10:15 a.m. The policy indicated: "Purpose: To define process for nursing cleaning of multiuse medical equipment...Procedure: 1. Glucometers: 1. Are cleaned after each use with germicidal wipes."</p> <p>The manufacturer's directions for cleaning the blood glucose meter were provided by RN #5, on 2/20/13 at 10:15 a.m., and included, but were not limited to: "...3. Sanitize the glucose meter with any EPA approved disinfectant product that meets the 1:10 bleach solution. 4. Wipe the surface of the glucose meter including the test strip port and communication port after each use. Be careful to make sure no liquid goes into either port. Wipe the meter thoroughly; the treated surface must remain visibly wet for a full 2 minutes to attain complete disinfection. 5. If you find any blood stains on the device, make sure you clean it with caution. 6. Air dry the meter to sanitize completely before next use...."</p> <p>B. On 2/14/13, during the lunch meal in the assistive dining room, CNA #1 was observed grabbing knife by the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
	<p>sharp end and proceeded to butter a resident's bread with bare hands. No hand hygiene was observed before or after this incidence.</p> <p>On 2/14/13, during the noon meal, CNA #1 was observed grabbing resident cups overhead several times. CNA #1 was also observed touching/scratching her face, then assisting residents with the meal. No hand hygiene was observed.</p> <p>A policy and procedure for "Hand Washing" was provided by the Administrator on 2/21/12 at 4:26 p.m. The policy indicated, but was not limited to, "Definition: To thoroughly cleanse the hands with friction, soap, and water. Purpose: 1. Medical asepsis to control infection. 2. To reduce transmission of organisms from resident to resident. 3. To reduce transmission of organisms from nursing staff to resident. 4. To reduce transmission of organisms from resident to nursing staff. General instructions: 1. Hands should be thoroughly washed before and after providing resident care. 2. Proper hand-washing techniques must be followed at all times...1. Observe (standard) universal precautions or other infection control standards as approved by appropriate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN 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
	<p>facility committee. Follow the Centers for Disease Control (CDC) Guidelines for hand washing. 2. Wash your hands before and after all procedures...5. Wear gloves when coming in contact with blood or body fluids...."</p> <p>3.1-18(b)(1)(A) 3.1-18(b)(2) 3.1-18(l)</p>			