

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155616	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/22/2013
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NAME OF PROVIDER OR SUPPLIER  ROBERT E LEE	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00138545 and Complaint IN00130456.</p> <p>Complaint IN00138545-Substantiated. Federal/state deficiencies related to the allegation are cited at F441.</p> <p>Complaint IN00130456-Substantiated. Federal/state deficiencies related to the allegation are cited at F441.</p> <p>Survey Date: November 13,14, 15, 18, 19, 20, 21, &amp; 22 2013</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Survey team: Gwen Pumphrey RN,TC Joan Laux, RN Gloria Reisert,MSW</p> <p>Census bed type: SNF/NF: 57 Residential: 13</p>	F000000	<p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility is requesting a Desk Review of compliance for this plan of correction.</p>	

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><b>Total: 70</b></p> <p>Census payor type: Medicare: 12 Medicaid: 33 Other: 25 Total: 70</p> <p>Sample: 16</p> <p>These deficiencies reflect state findings cited in accordance with 410IAC 16.2.</p> <p>Quality review completed on November 27, 2013 by Cheryl Fielden RN</p>			
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F000253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, interview, and record review the facility failed to provide an environment that was in good repair as evidenced by peeling paint, jagged spackle, water stains, ceiling plaster hanging down, gouges in walls, black scuff marks on walls, scraped doors and walls in Resident's rooms and carpet tears and ceiling tile water stains in the hallway. This deficient practice affected 11 out of 30 Residents sampled and 2 hallways observed for environmental concerns. This deficient practice had the potential to affect all Residents currently residing in the facility. (Resident #9, #10, #13, #28, #29, #31, #37, #44, #54, #58, and #66)</p> <p>Findings include:</p> <p>On 11/14/13, beginning at 9:25 a.m., the following was observed:</p> <p>Resident #31 room 122A had paint peeling from the wall surrounding the left side of the soap dispenser in the bathroom.</p>	F000253	<p>1. The environmental concerns identified during the survey were addressed and corrected immediately. The residents had no negative outcomes related to these concerns.2. A complete audit of the facility was completed by the Administrator and the Director of Maintenance to identify any area of concern and a plan developed to correct the areas identified was put into place.3. An audit form was created to be utilized by the Maintenance Director on a weekly basis. The Maintenance Director was in-serviced on the new audit form and the utilization of. Any areas identified during the weekly audits will be addressed immediately. Work orders were also placed at each nursing station to allow staff to alert maintenance of any areas of concern they have noted. The weekly audits will be reviewed with the Administrator to ensure appropriate follow-up and compliance.4. The Administrator and/or Designee will complete an environmental audit to ensure compliance. Each area of the facility will be audited weekly x4 weeks then monthly x5 months then quarterly. The audits will be completed Monday –</p>	12/22/2013			

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	<p>Resident #54 room 109P had white spackle at the meeting of the edge of the wall and the bathroom wall with white spackle that had not been painted. The spackle was dry and the 2 edges where the walls meet were rough and jagged. The area had not been smoothed out.</p> <p>Resident #13 room 105P had a ceiling tile in the far right corner of the bathroom that had a round water stain on it.</p> <p>Resident #66 room 110B had a large water stain (10x10 inches) on the ceiling, with ceiling plaster chipped off and a 4 inch strip of plaster hanging down from the stain above the right side of the window on the ceiling. A water stain (palm size) was also observed on the ceiling in the same vicinity.</p> <p>Resident #28, room 108B had multiple gouges in the wall opposite his bed from a foot above the floor to 3 feet above the floor. These gouges are dime size. Some of the gouges have been filled in with spackle and are dry, other gouges have not been painted over, and most have had nothing done to them.</p> <p>Resident #9, room 106A had black</p>		<p>Friday. The audits will be reviewed by the QA committee to ensure compliance and assess for the need for policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>				

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	<p>scuff marks on the wall next to the sink in his bathroom.</p> <p>Resident #37 room 49A the wall by the bathroom and the bathroom door scraped.</p> <p>Resident #10, room 125P had a urine odor in the bathroom and the bathroom door had scrapes across it.</p> <p>Resident #44, room 131P had rusty pipes and the ceiling tiles in the bathroom were discolored with a few hanging down.</p> <p>Resident #58, room 132B had gouges in the wall in the bathroom and her baseboard was peeling around her bed area.</p> <p>Resident #29, room 124A had a urine odor in the bathroom and scuff marks around the bathroom door.</p> <p>On hall 4, half way down the hall had a 2 and 4 inch tear with fraying. The fraying is 2 inches apart and in the middle of the hall.</p> <p>On hall 1, next to the maintenance closet had a ceiling tile with a hand size brown water stain.</p> <p>On 11/20/13 at 2:25 p.m., during an</p>			

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	<p>interview with the Director of Maintenance, he indicated "I try to do it right away; if it's a Resident we try to take care of it promptly, like a hole in the wall we try to get it scheduled so we can patch it and fix it within 3 days. We try to arrange when it's convenient for the Resident. If it's something reported we are given work orders, housekeeping will give them to us when they see something. They have orders on their carts to fill out when they see something. If it happens when we aren't here, we can come in on call or the next morning we take care of it first thing before we do anything else. If I see something we try to do it right then and there. Like I said, if its resident related, we do it right away. If it's not involving a Resident then we get to it as soon as we can. If its water related, we do it right away, if it's a light bulb we get to it that day. We prioritize what is the most urgent to the least. Anything in a Resident room, like a light bulb, it's a first top priority. If it's a hole in a wall made by a wheelchair or a bed, we make arrangements to get it fixed as soon as we can, within 3 days if we can. We in the facility fix all holes, gouges. We do not contract with an outside repair service."</p> <p>At 2:35 p.m., during an interview with</p>			

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	<p>the Administrator he indicated "Based off of the severity of the problem, is it an emergency, can we put it on the maintenance log. Safety concerns would be immediate. Immediate would be like an outlet damaged. It would be repaired right then and there. If it were not an emergency we would schedule it, like a wall repair, we would start the process as soon as possible. We would tape or mud the wall first to let it dry. I would expect maintenance to have a non emergency repair to be done within a matter of days, not weeks. I would hope it would not be weeks."</p> <p>At 2:44 p.m., during an interview with maintenance worker #1 he indicated "If I find something I fix it right away if it's simple. If it's a gouge or something you spackle it within 1-2 days, we try to. Sometimes it's reoccurring, so it's a constant repair. It is about the Resident's. I like to help people; they appreciate the little things, so I try to get things repaired right away. If it's an emergency we fix it immediately as soon as we find it or if someone on the staff tells us. We are on call, so we come in if it's an emergency. For repairs I go around once a month to fix the scratches, gouges and try to do that once a week or monthly. We try to keep a</p>			

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	<p>routine.</p> <p>On 11/20/13 at 2:50 p.m., the Administrator was observed walking up and down on the 400 Hall with a pen and pad in hand, going in and out of each room. When approached, he smiled and said we were checking each and every room for any damage or repairs needed. He kept asking for what was found and in what rooms.</p> <p>At 4:30 p.m., the Director of Maintenance was observed in Hall 4 spackling several Resident's room.</p> <p>On 11/21/13 at 11:05 a.m., a review of the "Job Description-Maintenance" for the Director of Maintenance indicated: "Maintains and repairs physical structures of buildings." Competency: "Identifies and resolves problems in a timely manner...follows policies and procedures...able to deal with frequent change, delays, or unexpected events...completes tasks on time...meets productivity standards, completes work in a timely manner."</p> <p>At 11:20 a.m., a review of the "Job-Description-Maintenance" for maintenance workers indicated: "Maintains and repairs physical structures of buildings. Receives</p>				

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	<p>written work orders or verbal orders." Competency: "Identifies and resolves problems in a timely manner...responds to requests for service and assistance...meets commitments...follows policies and procedures...follows instructions, responds to Administrator's direction...prioritizes and plans work activities...ability to apply common sense and mechanical understanding to carry out instructions furnished in written, oral, or diagram form."</p> <p>At 11:30 a.m., a review of the "Standards and Guidelines" for environment indicated: "Standard: The company maintains its facilities in accordance with all federal, state, and local code requirements...to provide a safe, functional, and clean environment for residents." "Guidelines: By managing the environment effectively a quality assurance system with help to reduce and control risks associated with environmental hazards and maintain safe conditions for residents, staff, and visitors." "The company recognizes the resident's needs and understands the importance of maintaining a homelike atmosphere. This ensures the safety of residents...while maintaining the resident's comfort and dignity."</p>			

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	<p>"Written documentation will be kept for the following items: preventative maintenance program...work orders."</p> <p>At 1:00 p.m., a review of the "Maintenance needed" form indicated the following repairs were made in the facility during the months of September, October, and November, 2013.</p> <p>September:</p> <p>9/4/13 Room 16 Tightened outlets and replaced cover 9/13/13 Room 102 Ck function, ck ok 9/13/13 Room 31 Replaced bulb 9/14/13 Room 25 Replaced bulb</p> <p>October:</p> <p>10/7/13 Room 27 Replaced bulb 10/15/13 Room 127 Replaced bulb, adjusted TV 10/16/13 Room 29 Mudded and sanded and painted 10/31/13 Room 21 Replaced toilet valve</p> <p>November:</p> <p>11/9/13 2nd floor hallway Ordered covers 11/11/13, received 11/15/13 11/9/13 Room 105 Patched wall</p>				

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	<p>hung picture 11/17/13 Room 112 Replaced bulbs 11/17/13 Room 227 Hung towel holder that was provided</p> <p>On 11/21/13 at 1:20 p.m., during an interview with the Administrator, he indicated that they did a complete audit of the Resident's rooms. They have also put together a new audit tool to monitor the work that needed to be done in the Resident rooms.</p> <p>On 11/21/13 at 3:05 p.m., during a review of the "Building Services Working Order" for the months of September, October, and November, 2013, they indicated:</p> <p>September:</p> <p>9/14/13 Electrical outlet between beds is very loose room 16. (Done) 9/13/13 Call light in 31 not lighting up outside the room in the hall. (Done) 9/13/13 Red outlet behind bed B would not charge residents wound vac in bed A. (Done) 9/14/13 Overhead light in room 25, not working. (Done) 9/16/13 Bathroom needs long light in it. (Done)</p> <p>October:</p>						

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	<p>10/15/13 Room 127 needs light bulb in light in front of door and light bulb in bathroom. Also, he would like you to look at his TV. States pictures not as clear as it was before the move. (Done)</p> <p>10/16/13 Wall by window needs to be sanded and painted. (Done)</p> <p>10/31/13 Toilet doesn't flush in room 21. (Done)</p> <p>November:</p> <p>11/9/13 Cover fire alarm boxes on Alzheimer's unit. (Done)</p> <p>11/9/13 Wall over resident bed needs patching. Resident wants picture hung on wall. Room 105. (Done)</p> <p>11/11/13 Needs light bulb in bathroom, room 112, it is blinking. (Done)</p> <p>11/17/13 Family asked if maintenance could install this in resident's room, as requested. (Done)</p> <p>A review of the "Monthly Preventive Maintenance Record" indicated that each month from January, 2013 to October, 2013 the following had been checked in each Resident's room and if needed, the work completed.</p> <p>Paint walls and door frames: "Patch any scrapes or holes in walls, sand and paint. Check doors and door</p>			

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	<p>frames for scratches and paint." Check plugs and switches: "Check rooms for broken outlets and covers. Make sure light switches function properly." Air conditioning units in rooms: "Check room air conditioning for proper function and check and change filters." Check floors for loose or broken tile: "Check floor tiles for cracks or that are loose from the floor. Replace if any." Check tubs and sinks for water drips: "Check for drips from spouts and leak under sinks." Check for lights being out: "Check over bed lights and entry lights for proper function." Check proper call light function: "Check hallway calls light and bathroom and bedside for proper function."</p> <p>3.1-19(f)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to monitor the resident's bowel movements, provide PRN [as needed] medications and dietary interventions related to the management of constipation for 1 of 1 resident reviewed for constipation in a sample of 5. (Resident #72)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #72 on 11/20/13 at 9:48 am, indicated the resident had diagnoses which included, but was not limited to: exacerbation of end stage chronic obstructive pulmonary disease, bronchitis, hypertension, anxiety, and atrial fibrillation.</p> <p>Admission orders for 11/6/12 included the following BOWEL PROTOCOL: - Milk Of Magnesia [MOM] - 30 cc [cubic centimeter] PRN [as needed] if no Bowel movement in 3 days - Dulcolax suppository 10 mg prn in</p>	F000309	<p>1. Resident #72 was assessed and found to have no negative outcomes. A complete review of resident #72 medications was completed by the Physician and any changes made as warranted. The care plan was reviewed and revised.2. Bowel sheets and protocols were reviewed for all residents and no other residents were found to be effected.3. All Nurses and QMAs were in-serviced on the Bowel Protocol and the importance of. The Bowel Protocol Form was reviewed and revised to facilitate program compliance.4. The DON and/or Designee will audit the Bowel Protocol for 5 residents daily x4 weeks, then 5 residents weekly x4 weeks, then monthly x4 months. Audits will be completed Monday – Friday. The audits will be reviewed by the QA committee to ensure compliance and to identify any need for policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>	12/22/2013	

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	<p>evening if no results from MOM - Enema prn in morning if no results from Dulcolax suppository</p> <p>On 5/23/13, a telephone order was received for Miralax - 17 grams in 8 ounces of water every night for constipation.</p> <p>On 6/11/13, new telephone orders were received for Colace 100 milligrams [mg] - 1 tablet every night and Senokot - 1 tablet - both for constipation.</p> <p>On 9/16/13, new telephone orders were received to discontinue the current orders for Senokot and Colace and to increase the dosage from 1 tablet to 2 tablets on both medications every night for constipation.</p> <p>Review of May, June, August and September 2013 Bowel and Bladder records indicated the resident would have 4-5 days in between bowel movements and when he did, the stool would usually be hard formed. Review of the nursing notes between 5/1 and 9/16/13 failed to document if the resident was having increased episodes of constipation. Documentation was also lacking of the PRNs being offered to the</p>			

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	<p>resident before increasing the resident's Senokot and Colace.</p> <p>During an interview with LPN #10 on 11/20/13 at 11:35 a.m., she indicated "The resident's diet intakes fluctuates from good to bad which in turn affected his bowels not moving as well. The increase in his meds may have been because it was during a period where his intakes were poor."</p> <p>On 11/20/13 at 3:15 p.m., LPN #11 indicated "We have a bowel protocol we follow. Night shift nurse looks at the CNA [certified nursing assistants] bowel records on each patient and makes a list of who has not had a BM to the morning shift to give the resident MOM. The afternoon shift then gives the suppository if no results from the MOM. Then the next morning, the resident would receive a Fleets enema if no results from the Suppository."</p> <p>On 11/20/13 at 3:00 p.m., the Director of Nursing presented a copy of the facility's current policy titled ""Management of Constipation." Review of the policy at this time included:: "Policy: It is the policy of this facility to assist residents to maintain normal bowel movements. Procedure: The Nursing Assistants</p>						

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	<p>will document bowel movements on the BM monitoring Log at the end of each shift. It shall be the responsibility of the Charge Nurse on each shift to monitor the documentation of bowel movements by the Nursing Assistants. The 10p - 6a Charge Nurse will complete the laxative list for any resident not having a bowel movement in 3 days. laxative Protocol: The 6a - 2p Charge nurse will offer the PRN laxative, if refused the refusal will be documented in the Nursing Notes. If the laxative is refused x 3 within a 24 hour period the MD and family must be notified, the notification and response will be documented in the Nursing Notes. If no bowel movement the 10p - 6a Charge Nurse will give a suppository as ordered. If no bowel movement a fleets enema should be given as ordered. If no bowel movement the MD must be notified, new orders noted and initiated."</p> <p>On 10/18/13, a Care Plan was developed to address "The resident has potential for constipation r/t [related to] nonambulatory and refuses to get OOB [out of bed] most rimes, medications side effects and diminished appetite." Goal "Will have a normal bowel movement at least every third day through next review".</p>			

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	<p>Approaches included: "Encourage proper hydration and nutrition daily; Follow facility bowel protocol for bowel management; medications as ordered; Monitor medications for side effects of constipation. Keep physician informed of any problems; Monitor/document/report to MD PRN s/sx [sign/symptoms] of complications to constipation, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, agitation, abdominal distention, vomiting, small loose or stools, bowel sounds, tenderness, guarding, fecal compaction, rigidity; record bowel movement pattern each day. Describe amount and consistency."</p> <p>Review of the dietary notes between 5/1 and 11/20/13 also failed to locate documentation by the dietitian of having addressed the resident's constipation.</p> <p>During an interview with the DON and Assistant Director of Nursing [ADON] on 11/20/13 at 4:00 p.m., they indicated that a resident's medications might be increased if they were showing signs of a problem. When queried about the bowel protocol being utilized before getting an order to increase the bowel</p>				

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	<p>motility medications, the DoN indicated that sometimes it was not used if the resident already has medicines that work.</p> <p>When informed of the lack of documentation in the nursing notes and on the Medication Administration Records [MARs] of the PRN medications being offered and whether the resident refused them, she indicated that it should have been before the routine medications were increased.</p> <p>During an interview with the DON on 11/21/13 at 9:30 a.m., she indicated that although it was not documented, she spoke with the CNAs and nurses who had indicated to her that the reason the Nurse Practitioner [NP] increased his medications was because when he had a BM, it was usually hard, so she increased the meds to keep it more consistent and softer. Staff were also inserviced on documenting those reasons for better clarity regarding the changes.</p> <p>On 11/21/13 at 9:36 a.m., the Medical Records Clerk presented the prior care plan titled "At risk for constipation" which had been pulled off the clinical record when the new one had been written. Review of this</p>			

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	<p>care plan at this time included approaches such as "1. Give stool softener/Cathartic per MD [physician] order; 5. Give prn laxative if no bowel movement in three days - facility bowel protocol."</p> <p>3.1-37(a)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents received preventative treatments to prevent pressure ulcers. This deficient practice was based on 1 of 3 residents in a sample of residents reviewed for pressure ulcers. (Resident #44)</p> <p>Findings include:</p> <p>Resident #44 was observed multiple times on 11/14, 11/15, 11/18, and 11/19/2013 laying flat on a specialty mattress. Resident was not observed to be laying in a different position.</p> <p>Review of the clinical record on 11/18/13 at 9:11a.m., showed a physician order dated 11/13/13. The physician order indicated "cleanse</p>	F000314	<p>1. Resident #44 was admitted to the facility with Hospice services (Comfort Care Only) and expired during the Survey.2. The facility had one other pressure area which was admitted with. This area is now healed. No other residents were affected.3. All existing residents and/or new admissions presenting with the potential for skin breakdown have been or will be upon admission or with a change in status to ensure appropriate measures are in place to assist in the prevention of skin breakdown. The care plans will be reviewed and/or implemented to reflect the current plan of care.4. Weekly skin assessments are completed on all residents by the nurse. Any areas of concern noted are addressed immediately and a skin review sheet will be completed and give to the Wound Care Nurse. The Wound Care Nurse reviews, measures and</p>	12/22/2013	

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	<p>wound to coccyx with NS, pat dry, apply thin layer of santyl and sprinkle polysporin on wound. cover with absorbent dressing change each day"</p> <p>The care plan was reviewed on 11/18/13 at 9:11a.m.. A care plan was initiated on 10/21/13 related to unstageable coccyx pressure ulcer. The care plan indicated "res needs assistance to turn/reposition q2h [every 2 hours]. Review of the care plan did not indicate the resident refused care.</p> <p>The weekly wound evaluation forms were provided by the Assistant Director of Nursing (ADON) on 11/18/13 at 11:33a.m., indicated the resident acquired the pressure ulcer to her coccyx on 9/6/13 while in the facility. The wound was documented as a stage 1 on 9/6/13 thru 10/23/13 with the treatment being duoderm. The size of the pressure ulcer was the same during these dates. The wound sheet dated 10/30/13 indicated the pressure ulcer advanced to an unstageable with slough and/or eschar. The size of the pressure ulcer had increased to 7x6.5</p> <p>A review of the laboratory report dated 11/17/13 indicated the pressure ulcer was cultured. The report</p>		<p>ensures appropriate treatments are in place and updates the plan of care as warranted. The wound records are completed for each resident as indicated by the skin condition on a weekly basis. A complete wound report is developed by the Wound Care Nurse and provided to the Administrator, DON, Dietician and DSM to ensure appropriate follow-up. The IDT team will review the wound reports weekly to ensure proper protocols are in place and compliance with the wound program. Reviews will be documented on each residents IDT note. The wound reports and IDT notes will be reviewed by the QA committee to ensure compliance and to assess for the need of policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>				

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	<p>indicated a heavy growth of e.coli and proteus mirabilis.</p> <p>The ADON indicated in an interview on 11/18/13 at 2:31p.m., the resident was at high risk for pressure ulcers based on her previous medical history. The resident was a hospice patient that had a bony prominence upon admission. He indicated the first treatment was a duoderm dressing over her coccyx. The staff encouraged the resident to turn every 2 hours. The resident had poor intake we addressed it by having the dietician evaluate her. We offered her protein shakes but she did not like them.</p> <p>He indicated when the residents pressure ulcer worsened to an unstageable a pressure mattress was ordered and her treatment interventions had changed. The ADON indicated, "the air mattress is our miracle worker". He indicated the treatment changed from the duoderm to a more padded dressing to give it more protection. He indicated the pressure ulcer was recently cultured and the resident was placed on an antibiotic.</p> <p>On 11/19/13 at 8:38a.m., the Director of Nursing (DoN) indicated the</p>			

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	<p>resident had been non compliant with nutrition. The resident was admitted with a Stage 1 [pressure ulcer] and was treated with duoderm. The DoN indicated the resident has multiple co-morbidities that affected the residents wound healing and that she is "surprised she[the resident] has lasted this long." The DoN indicated hospice informed the facility the resident had a healed stage 2 to the coccyx. She was unable to provide documentation related to the resident's previous pressure ulcer.</p> <p>A copy of the policy titled, "Wound/Skin Protocol/Documentation" was provided by the DoN on 11/19/13 at 8:46a.m. The policy indicated "...the care plans would be updated weekly or more frequently as warrented. Documentation of the refusal of procedures and/or interventions related to wound healing would be documented in the resident's record..." The facility was unable to provide evidence that the resident refused to be repositioned or that interventions were present to prevent the development of a unstageable pressure ulcer.</p> <p>3.1-40(a)(1)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure PRN [as needed] constipation medications were utilized prior to initiating new medications and/or increasing the dosage of the routine medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #72)</p> <p>Finding includes:</p>	F000329	<p>1. Resident #72 was reviewed and found to have no negative outcomes. A complete review of resident #72s medications was completed by the Physician and any changes made as warranted. The Dietician reviewed for recommendations related to potential for constipation.2. The BM Protocol for all residents was reviewed and no other residents were found to be affected.3. All nurses were in-serviced on the proper bowel protocol, reason for and following the policy related to in order to avoid any increases in</p>	12/22/2013			

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	<p>Review of the clinical record for Resident #72 on 11/20/13 at 9:48 am, indicated the resident had diagnoses which included, but was not limited to: exacerbation of end stage chronic obstructive pulmonary disease,, bronchitis, hypertension, anxiety, and atrial fibrillation.</p> <p>Review of the Admission Orders dated 11/6/12 indicated the resident had PRN [as needed] orders for Milk Of Magnesia - take 30 cc [cubic centimeters] by mouth as needed if no bowel movement in 3 days; Dulcolax suppository 10 mg [milligrams] - insert 1 suppository per rectum as needed - give in evening if no results from Milk Of Mag; Enema - use 1 enema rectally as needed in the morning if no results from Dulcolax suppository.</p> <p>Review of the resident's physician orders indicated a telephone order dated 5/23/13 for Miralax 17 grams in 8 ounces of water every night for constipation.</p> <p>On 6/11/13, a new telephone order was received for Senokot - 1 tablet every night for constipation and Colace 100 mg - 1 tablet every night for constipation.</p>		<p>medications if not warranted. The Bowel Protocol Form was reviewed and revised to facilitate proper follow through and policy compliance.4. The DON and/or Designee will audit the bowel protocol for 5 residents daily x4 weeks, then 5 residents weekly x4 weeks, then 5 residents monthly x4 months to ensure compliance. Audits will be completed Monday – Friday. The audits will be reviewed by the QA committee to ensure compliance and or to identify the need for policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>				

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	<p>On 9/16/13, new telephone orders were received to increase the Senokot and Colace from 1 tablet to 2 tablets every night.</p> <p>Review of the May, June, August and September 2013 Bowel and Bladder records indicated resident would have 4-5 days in between bowel movements. Review of the nursing notes between 5/1 and 9/16/13 failed to document if the resident was having increased episodes of constipation. Documentation was also lacking of the resident having been offered the PRN constipation medications before the routine medications were increased.</p> <p>During an interview with LPN #10 on 11/20/13 at 11:35 a.m., she indicated "The resident's diet intakes fluctuates from good to bad which in turn affected his bowels not moving as well. The increase in his meds may have been because it was during a period where his intakes were poor."</p> <p>During an interview with the Director of Nursing [DON] and Assistant Director of Nursing [ADON] on 11/20/13 at 4:00 p.m., they indicated that a resident's medications might be increased if they were showing signs of a problem. When queried about</p>						

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	<p>the bowel protocol being utilized before getting an order to increase the bowel motility medications, the DoN indicated that sometimes its was not used if the resident already had medicines that work.</p> <p>When informed of the lack of documentation in the nursing notes and on the Medication Administration Records [MARs] of the PRN [as needed] medications being offered and whether the resident refused them, she indicated that it should have been before the routine medications were increased.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</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.</p> <p>Based on observation, record review, and interview the facility failed to ensure residents received inhalers according to the proper technique. This deficient practice was based on 2 of 7 observations of medication administration. The medication error rate was 8%. This deficient practice had the potential to affect residents currently residing in the facility. (Resident #40 and Resident #37)</p> <p>Findings include:</p> <p>1. QMA #1 was observed on 11/19/13 at 9:16a.m. administering [named] inhaler to Resident #40. After administration of the medication, the QMA did not allow the resident to rinse his mouth.</p> <p>Resident # 40 clinical record was reviewed on 11/19/13 at 2:30p.m. He had diagnoses including but not limited to heart disease, COPD, and contipation.</p> <p>The Medication Administration Record was reviewed for November</p>	F000332	<p>1. Resident #40 and #37 were reviewed and found to have no negative outcomes related to not being offered water after the administration of the inhaler treatment.2. No other residents were found to be affected.3. The Nurses and QMAs were in-serviced on the proper administration of inhalers and the importance of offering water to rinse the mouth after administration. All new Nurses and QMAs will be in-serviced on the inhaler administration policy upon hire and all existing Nurses and QMAs will be checked off annually thereafter.4. The DON and/or Designee will audit 5% of residents receiving inhalers by watching staff administration on a daily basis x4 weeks, then weekly x4, then monthly x4. Any areas of concern will be addressed immediately. Audit will be completed Monday – Friday. The audits will be reviewed by the QA committee to ensure compliance and assess for the need of policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>	12/22/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155616		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/22/2013	
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	<p>2013 and indicated, Advair 250/50 Inhale 1 puff two times daily. rinse mouth after use.</p> <p>2. QMA#1 was observed on 11/19/13 at 9:04a.m. administering [named] inhaler to Resident #37. After administration the medication, the QMA did not allow the resident to rinse his mouth.</p> <p>Resident #37's clinical record was reviewed on 11/19/13 at 2:40p.m. He had diagnoses including but not limited to neuropathy, GERD, pain, and dempntia.</p> <p>The Medication Administration Record was reviewed for November 2013 and indicated, Spriva 18mcg inhale contents of 1 capsule daily.</p> <p>In an interview on 11/19/13 at 9:27a.m., QMA #1 indicated she didn't think about rinsing the residents mouth after using the inhaler.</p> <p>A copy of the policy titled, "Oral Inhalation Administration" was provided by the DoN on 11/20/13 at 11:05a.m. The policy indicated..."Have resident rinse his/her mouth and spit out the rinse water. Remove the inhaler from the holding chamber or spacer. Rinse</p>						

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	and dry the inhaler mouthpiece and the holder chamber or spacer..."  3.1-25(b)(9) 3.1-48(c)(1)(2)			

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure Consultant Pharmacy recommendations were acted upon in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident #72)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #72 on 11/20/13 at 9:48 am, indicated the resident had diagnoses which included, but was not limited to: exacerbation of end stage chronic obstructive pulmonary disease, bronchitis, hypertension, anxiety, and atrial fibrillation.</p> <p>Review of the monthly Consultant Pharmacist recommendations between November 2012 and October 2013, the following was noted: - "11/24/12 - ..., new admit, Dx</p>	F000428	<p>1. Resident #72 was reviewed and had no negative outcomes related to the delayed pharmacy reviews. Resident #72 was reviewed with the Pharmacy consultant and pharmacy consultant recommendations were complete.2. A meeting was held with the Pharmacy Consultant and a review of pharmacy recommendations completed. No other residents were found to be affected.3. The MD or NP will review all pharmacy recommendations during their weekly facility visits to ensure timely follow-up. The Administrator and DON met with the Pharmacy consultant to review and revise the process to ensure compliance. A binder will be maintained by the DON to allow for easy review of the pharmacy recommendations and ensure follow-up has occurred. A copy of the Physician response will be placed on the chart by the Pharmacy review sheet for review by the Pharmacy Consultant to ensure compliance and timely follow through.4. The DON will</p>	12/22/2013	

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	<p>[diagnoses] needed for meds." - "1/31/13 - ...resent indication for Klonopin [anxiety medication] and Protonix [stomach medicine]..." - "3/20/13 - Wt [weight] not documented for March yet...resent requests for documentation of diagnoses." - "4/20/13 - Wt [weight] stable, resent requests for clarification." - "5/29/13 - resent clarification requests, Poly Rx [pharmacy] review, missing Vitamin D Level." - "6/28/13 - stall awaiting address labs..." - "7/31/13 - resent Vitamin D labs requests, Poly Rx, Klonopin Dx [diagnosis]?" - *8/29/13 - Vit D 62, still need Klonopin Dx (6th request)"</p> <p>Review of the Lab Section of the clinical record indicated that although the Vitamin D level was drawn on 5/2/13 per physician's order, the result was not followed up on and placed in the clinical record until 8/6/13 - 3 months after it was drawn.</p> <p>Review of the telephone orders also noted the diagnosis for Klonopin was not received until 9/13/13 although the request had been first made 8 months earlier.</p>		<p>review the Pharmacy Recommendations with the Administrator on a monthly basis x6 to ensure proper and timely follow up has occurred. The pharmacy recommendations will be reviewed by the QA committee to ensure compliance. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>	

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	<p>During an interview with the Director of Nursing [DON] and Assistant Director of Nursing [ADON] on 11/20/13 at 4:00 p.m., they indicated that they used to notify the physician about the pharmacy recommendations and they would just tell her to send them to the office and as a result, they'd lose them. The DON indicated in the last 6 months, she has begun sitting down with either the physician or Nurse Practitioner [NP] who come in twice a month and actually go over them and get the response then.</p> <p>She indicated that it was also the pharmacist's responsibility to help the facility get responses from the physician and that she hasn't been doing that either. The DON indicated that sometimes the pharmacist does not look thoroughly through the chart to find the things she was requesting; i.e. diagnoses, labs, etc. and will just make a new request - that was why it appeared as she was making multiple requests for items that were already in the chart.</p> <p>On 11/20/13 at 3:00 p.m., the Director of Nursing presented a copy of the facility's current policy titled "Section 49: Documentation and Communication of Consultant</p>			

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	<p>Pharmacist Recommendations Policy. Review of this policy at this time included, but was not limited to: "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. Procedures: A. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, physician, and the care planning team, This should include:...3) The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review....C. Recommendations are acted upon and documented by the facility staff and/or prescriber. If the prescriber does not respond to recommendation directed to him/her within a reasonable timeframe, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director..."</p> <p>3.1-25(h)</p>			

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	3.1-25(i)				

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; 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 properly</p>	F000431	<p>1. Residents #14, 34 and 46 were assessed and found to have no negative outcomes. All identified expired or unlabeled medications were discarded or</p>	12/22/2013			

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	<p>stored and labeled. This deficient practice was based on 4 of 6 medication carts and 3 of 3 medication rooms observed. This deficient practice had the potential to affect all residents currently residing in the facility.(Resident #14, 34, 46, 48, and 56).</p> <p>Findings include:</p> <p>1. An observation of the medication cart on Hall 1 on 11/19/13 at 9:22a.m., indicated the following:</p> <ul style="list-style-type: none"> <li>-4 vials of Albuterol 0.83% in the top drawer without a label</li> <li>-5 vials Albuterol 0.83% in the bottom drawer without a label</li> <li>-2 vials of Extavia 0.3 with no label</li> </ul> <p>In an interview on 11/19/13 at 9:32a.m., QMA #1 indicated she was unable to identify whom the vials of Albuterol belonged to and disposed of them. She indicated the Extavia belonged to Resident #14.</p> <p>In an interview on 11/19/13 at 9:45a.m., LPN #5 indicated she contacted the pharmacy and they would send a label for Resident #14's medication. She indicated the pharmacy will label each package instead of the box only as they did</p>		<p>addressed appropriately immediately.2. All Medication storage areas were reviewed and no other areas of concern were identified. No other residents were found to be affected.3. All Nurses and QMAs were in-serviced on the policy related to the proper labeling , dating and storage of as well as discarding of d/c or expired medications. New auditing procedures were put into place to ensure the above areas of concern do not reoccur. All Nurses and QMAs are responsible for following the above policy and auditing their carts and medication storage areas daily to ensure compliance. An audit form was created to be utilized by night shift on a daily basis and will be turned into the DON or ADON daily.4. The Don and/or Designee will audit all medication carts and medication storage area weekly x4 then monthly x5 to ensure compliance. Any areas of concern will be addressed immediately. The audits will be reviewed by the QA committee to ensure compliance and assess for the need of policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>				

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	<p>before. She indicated the staff probably took the medication out of the box from the medication storage room because the box would not fit in the medication cart. When the medication room was observed, there was no box to be found with a label for Resident #14's Extavia.</p> <p>2. An observation of the medication storage room on Hall 1 on 11/19/13 at 9:34a.m., indicated the following:                      -1 vial of Tubersol 5tu/0.1ml opened with no open date on the vial                      -6 bottles of Milk of Magnesia 12 fl oz with an expiration date of 10/13 for Residents #14, 34, 46, 48, and 56.</p> <p>In an interview on 11/19/13 at 9:45a.m., QMA #1 nor LPN #5 could identify when the vial of Tubersol was opened. LPN removed the tubersol from the storage room. She indicated she would ask the DoN for guidance. She returned to indicate the vial would be disposed of.</p> <p>QMA #1 indicated the 6 bottles of Milk of Magnesia would be sent back to the pharmacy and placed them in bin.</p> <p>3. An observation of the medication cart for Hall 4 on 11/19/13 at 10:10a.m., indicated the following:</p>			

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NAME OF PROVIDER OR SUPPLIER  ROBERT E LEE	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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	<p>-4 vials of albuterol with no label</p> <p>-1 vial Novolin N-unopened in the bottom drawer of the medication cart with no label. This vial should have been stored in the refrigerator.</p> <p>- 1 vial Novolin N-unopened in the top drawer of the medication cart for Resident #84. This vial should have been stored in the refrigerator.</p> <p>LPN #6 indicated in an interview on 11/19/13 at 10:19a.m., the Novolin N insulin belonged to Resident #84. She was not sure whom the vials of albuterol belonged to.</p> <p>4. An observation of the medication storage room for Hall 4 on 11/19/13 at 10:36a.m., indicated the following:</p> <p>- 1 vial of Tubersol 5tu/0.1 ml with an open date of 10/11/13</p> <p>LPN #6 indicated in an interview on 11/19/13 at 10:40a.m., the the vial of Tubersol was "good for 3 months".</p> <p>5. An observation of the medication storage room for the Alzheimer and Residential units on 11/19/13 at 11:15a.m., indicated the following:</p> <p>- 1 vial of Tubersol 5tu/0.1 ml opened with no open date on the vial</p> <p>In an interview with LPN #7 on</p>			

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	<p>11/19/13 at 11:17a.m., indicated she was not sure when it was opened but I'll get rid of it. She then removed the vial from the storage room.</p> <p>A copy of the policy titled, "Medication Labels Policy" was provided by the DON on 11/20/13 at 11:05a.m. The policy indicated,... "Improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy."</p> <p>A copy of the policy titled, " Storage of Medication Policy" was provided by the DON on 11/20/13 at 11:05a.m. The policy indicated,... "Outdated, contaminated, or deteriorated medications and those in containers that are cracked soiled, or without secure closures are immediately removed from stock. and reordered from the pharmacy if a current order exists..."</p> <p>A copy of the policy titled, " Medication/Destruction of" was provided by the DON on 11/20/13 at 11:05a.m. The policy indicated discontinued medications and/or expired medications should be removed from the medication cart promptly (to avoid inadvertent administration).</p>				

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	<p>A copy of the policy titled, " Vials and Ampules of Injectable Medications Policy" was provided by the DoN on 11/20/13 at 11:05a.m. The policy indicated the date opened and the initials of the first person to use the vial are recorded on multi-dose vials on the vial label or an accessory label affixed for that purpose. If a multi-dose vial shows visible evidence of precipitation or contamination or the rubber stopper is deteriorating it is not used and is returned to [named pharmacy]."</p> <p>3.1-25(j)(k)(l)(o)</p>			

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F000441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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 interview, and record</p>	F000441	1. Only three of the residents identified #31, 28 and 10	12/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155616		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/22/2013	
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	<p>review the facility failed to help prevent the development and transmission of infection. This deficient practice was based on the facility infection control program's lack of investigation with suspected facility wide spread of scabies to residents and employees. (Resident 44, 42, 38, 48, 19, 17, 88, 86, 31, 54, 64, 55, 72, 37, 58, 84, 1, 13,7, 45, 66, 29, 33, 28, 21, 10, 36, 56, 74, and 9)</p> <p>Findings Include:</p> <p>Review of the clinical records for Stage 1 sampled residents indicated all the residents were prescribed stromectol, an anitparasitic medication.</p> <p>In an interview on 11/14/13 at 2:26p.m., the MDS Coordinator indicated, "Stromectol is a preventative medicine for mites. We had a couple of residents with a rash, several [doctors] could not identify it, so we went across the board and gave it to everyone as prophylactic treatment".</p> <p>Review of the infection control log on 11/21/13 at 2:14p.m., lacked documentation of residents treated prophylacatically for scabies.</p>		<p>presented with rashes and are clear with no negative outcomes related to treatment. Residents # 38, 19, 17, 88, 86, 54, 84, 45, 21, 36 and 56 were not identified on the resident identifier list. Resident #1 and #9 reside in the Residential Unit. All residents were assessed and found to have no adverse effects from the treatment provided.2. No other residents showed adverse effects from the treatments ordered by the Physician.3. An infection control tool was created to list and follow the progression of rashes. All Nurses were in-serviced on documentation of the appropriate follow-up related to the treatments provided.4. The DON and/or Designee will audit any resident presenting with a rash including documentation, treatment and resolution of x6 months. The audits will be reviewed by the QA committee to ensure compliance and assess for the need of policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>				

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	<p>In an interview on 11/21/13 at 3:08p.m., the ADON indicated the facility tracts infections based on forms provided by the coporate office. He indicated that the facility did not have a confirmed diagnosis of scabies and therefore did not need to be tracked by the infection control program.</p> <p>In an interview on 11/21/13 at 3:37p.m., the DoN indicated the facility followed the direction of the medical director to treat all residents and staff with stromectol. She was unable to provide proof of the facilities investigation of the cause of the rash, complete assessments of the residents and staff with a rash, adverse side effects of the medication, or if the rash was resolved.</p> <p>A copy of the policy titled, "Infection Control" was provided on 11/21/13 at 11:40 a.m., by the ADON indicated,..."the objectives....are to prevent, detect, investigate, and control infections in the facility; maintain records of incidents and corrective actions related to inections.</p> <p>This Federal Tag relates to Complaint IN00138545 and Complaint IN00130456.</p>			

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	3.1-18(1)(2)(3)			

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F009999	<p>Based on interview and record review the facility failed to document notification of family with physician's orders. This deficient practice affected 1 of 30 clinical records reviewed. This deficient practice had he potential to affect all residents currently residing in the facility. (Resident #10)</p> <p>Findings include:</p> <p>The medical record for Resident #10 was reviewed on 11/20/13 at 4:00p.m. A physician order dated 10/16/13 indicated a physician order for Stromectol 3 milligrams, take 7 tabs by mouth now. The order lacked documentation of resident or family notification of change. A copy of this order was provided on 11/20/13 at 4:10p.m. by the Medical Records Clerk.</p> <p>On 10/22/13 at 8:52a.m., the Director of Nursing provided a copy of the physician order dated 10/16/13 for Resident #10. This order had documentation that both resident and family were notified of change in treatment on 10/16/13.</p>	F009999	<p>1. Resident #10 was interviewed and stated he was aware of the Stromectol treatment and why he was receiving it. No adverse effects were noted.2. No other residents were found to be affected.3. The Nurses and ADON were In-serviced on proper and timely notification of residents and family and the documentation related to.4. The DON and/or Designee will audit resident orders to ensure that proper/timely notification has been documented. 5 residents orders will be audited daily x4 weeks, then weekly x4 weeks, then monthly x4 to ensure compliance. Audits will be performed Monday – Friday. Audits will be reviewed by the QA committee to ensure compliance and assess for the need of policy revision and/or staff education. Continued compliance will be monitored utilizing the QAPI process.5. December 22, 2013</p>	12/22/2013	

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	<p>In an interview on 11/22/13 at 2:15p.m., the Administrator, DoN, and Assistant Director of Nursing were unable to provide an explanation as to how the physician order changed to show the resident and family were notified. The DoN indicated she would identify who added documentation to the physician's order after it was written.</p> <p>In an interview on 11/22/13 at 2:33p.m., the ADON indicated, "...I remember speaking to her(resident's family) and I signed it yesterday. I know I wasn't supposed to do that..."</p>			

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R000000	The following residential deficiency is cited in accordance with 410 IAC 16.2-5.	R000000	PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility is requesting a Desk Review of compliance for this plan of correction.		

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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview the facility failed to provide a minimum of 1 awake person with a current first aid certification on site at all times as evidenced by no staff members having first aid certification. This deficient practice had the potential to affect 15 of 15 residential residents residing in the facility.</p> <p>Findings include:</p>	R000117	<p>1. First Aid training was began immediately. The Residential area is staffed with LPNS and/or RNs 24/7. No residents were found to have negative outcomes.2. No other residents were affected.3. First Aid training was implemented immediately during the survey. Additional classes were held to ensure the appropriate staff members are certified in First Aid and that at least one staff member certified in</p>	12/22/2013	

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	<p>On 11/21/13 at 4:15 p.m., during an interview the DON (Director of Nursing) indicated that she had "Never heard of needing first aid certification needed on each shift for a residential facility."</p> <p>On 11/22/13 at 10:05 a.m., during an interview the Administrator indicated that "we have started a first aid course that is OSHA (Occupational Safety Health Administration) approved for staff yesterday (11/21/13)." No one on staff had first aid training before starting it on 11/21/13.</p> <p>A review of the "As Worked" schedule dated 11//14/13 thru 11/22/13 indicated no staff member had first aid training on any shift.</p> <p>During an interview at 11:15 a.m., the DON indicated she will "definitely get first aid training for the staff. It blows my mind that it is needed." The DON again indicated she had never heard of a residential facility needing to have a first aid certified staff member on each shift.</p>		<p>First Aid will be available on each shift. The Human Resource Director will maintain a binder containing the First Aid Certifications and will provide notice of expiration dates to maintain compliance.4. The Administrator and/or Designee will audit for continued compliance. An audit was conducted after the training classes to ensure an adequate number of staff was certified in First Aid. First Aid Cerifications will be audited monthly x6 months to ensure compliance. The audits will be reviewed by the QA committee to ensure compliance and assess for the need of policy revision and/or staff education.5. December 22, 2013</p>				

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R000301	<p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation and record review the facility failed ensure medications were properly labeled. This deficient practice affected 1 of 1 medication storage rooms observed. This deficient practice had the potential to affect all residents residing in the facility.</p> <p>Findings include:</p> <p>An observation of the medication storage room for Residential unit on 11/19/13 at 11:15a.m., indicated the following: - 1 vial of Tubersol 5tu/0.1 ml opened with no open date on the vial</p> <p>In an interview with LPN #7 on 11/19/13 at 11:17a.m., indicated she was not sure when it was opened but</p>	R000301	<p>1. The undated medication was disposed of immediately. No residents were negatively affected.2. All medication storage areas were reviewed no other areas of concern were identified. No other residents were found to be affected.3. The Nurses and QMAs were in-serviced on the policy related to proper dating and destruction of medications. A medication review form was developed and put into place to ensure all medications are checked daily for proper dating and timely destruction of d/c'd medications.4. The DON and/or Designee will review the medication forms daily to ensure compliance. Audits of the medications storage areas will be completed weekly x4, then monthly x5. The audits will be reviewed by the QA committee to</p>	12/22/2013			

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	<p>I'll get rid of it. She then removed the vial from the storage room.</p> <p>A copy of the policy titled, " Vials and Ampules of Injectable Medications Policy" was provided by the DoN on 11/20/13 at 11:05a.m. The policy indicated the date opened and the initials of the first person to use the vial are recorded on multi-dose vials on the vial label or an accessory label affixed for that purpose.</p>		<p>ensure compliance and assess for the need of policy revision and/or staff education.5. December 22, 2013</p>		

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R000356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> <li>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</li> <li>(2) The resident ' s hospital preference.</li> <li>(3) The name and phone number of any legally authorized representative.</li> <li>(4) The name and phone number of the resident ' s physician of record.</li> <li>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</li> <li>(6) Information on any known allergies.</li> <li>(7) A photograph (for identification of the resident).</li> <li>(8) Copy of advance directives, if available.</li> </ol> <p>Based on record review and interview, the facility failed to ensure the emergency files contained sufficient information and were available for each resident in the event of an emergency for 2 of 5 residents in a sample of 7 and 9 of 9 supplemental residents reviewed for emergency files (Residential Residents #R1, R2, R8, R9, R10, R11, R12, R13, R14, R15 and R16). This deficient practice had the potential to affect 15 of 15 Residential Residents currently residing in the facility.</p> <p>Findings included:</p>	R000356	<p>1. The emergency information book was updated immediately during survey to ensure complete and accurate information was present. No residents had negative outcomes.2. No other residents were found to be affected.3. The Nurses working on the Residential Unit were in-serviced on the proper completion and updating of the resident emergency book and the importance of.4. The DON and/or Designee will audit the emergency information book with each new admission or discharge to ensure continued compliance. Any areas of concern will be addressed immediately. Areas of concern will be brought to the QA</p>	12/22/2013	

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	<p>Review of the Current Emergency Files Binders on 11/21/13 at 12:00 p.m., indicated the following items were missing:</p> <ol style="list-style-type: none"> <li>1. Resident #R1 was admitted to the facility on 9/30/07. Apartment #232A was listed on the facesheet although the resident was currently residing in Apartment #234A effective 6/27/13.</li> <li>2. Resident #R2 was admitted to the facility on 11/6/13. No emergency file could be located which contained a picture of the resident, hospital preference, apartment number, physician name and phone number, known allergies and name and phone number of an emergency contact person.</li> <li>3. Resident #R8 was admitted to the facility on 9/18/13. No hospital preference was listed and the allergy section was blank.</li> <li>4. Resident #R9 was admitted to the facility on 1/20/06. Apartment #215 was listed on the facesheet although the resident was currently residing in Apartment #227 effective 6/25/13.</li> <li>5. Resident #R10 was admitted to the facility on 2/1/12. Apartment #206A was listed on the facesheet although</li> </ol>		committee for review and to assess for policy revision and/or staff education.5. December 22, 2013.		

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	<p>the resident was currently residing in Apartment #222A effective 6/6/13.</p> <p>6. Resident #R11 was admitted to the facility on 8/9/11. Apartment #204B was listed on the facesheet although the resident was currently residing in Apartment #232A effective 6/13/13.</p> <p>7. Resident #R 12 was admitted to the facility on 7/21/11. Apartment #212 A was listed on the facesheet although the resident was currently residing in Apartment 225 effective 6/5/13.</p> <p>8. Resident #R13 was admitted to the facility on 8/11/12. Apartment #213P [Private] was listed on the facesheet although the resident was currently residing in Apartment #233. A date of birth was also missing.</p> <p>9. Resident #R14 was admitted to the facility on 12/5/08. Apartment #210A was listed on the facesheet although the resident was currently residing in Apartment #224B effective 5/20/13.</p> <p>10. Resident #R15 was admitted to the facility on 2/28/11. Apartment #206B was listed on the facesheet although the resident was currently residing in Apartment 228B. No room change date was listed. The allergy</p>			

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	<p>section and the name and number for a legal authorized representative was also missing.</p> <p>11. Resident #R16 was admitted to the facility on 7/28/11. The allergy section of the face sheet was blank.</p> <p>During an interview with the Director of Nursing on 11/22/13 at 8:52 a.m., she indicated Resident #R2 was the only one missing information for an emergency file, but that it was present in the binder now.</p> <p>During the interview, she also presented a copy of the facility's current policy titled "Policy: Residential (Resident) Emergency Information. Purpose: To ensure the resident is identifiable and their immediate information is available in case of an emergency situation. Procedure: 1. A (Resident Profile Form) will be completed on each resident to the Residential Area. 2. Each Profile will include a photo of the resident. 3. If the Resident has Advanced Directives in place a copy will be attached. 4. The binder will be maintained on the residential Unit and updated by the staff."</p>			