

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 24, 2016.</p> <p>Survey dates: April 18 and 19 2016</p> <p>Facility number: 000562 Provider number: 155621 AIM number: 100267150</p> <p>Census bed type: SNF/NF: 59 SNF: 3 NF: 0 Residential: 22 Total: 84</p> <p>Census payor type: Medicare: 16 Medicaid: 34 Other: 15 Total: 84</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey.</p> <p>QR completed by 11474 on April 20,</p>	F 0000	<p>This Plan of Correction constitutes the written allegation of compliance for deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.</p>	
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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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F 0431 SS=F Bldg. 00	<p>2016.</p> <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</p>						

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	<p>dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure corrective action was followed to store medications and biologicals in a hygienic and orderly manner for 2 of 2 medication rooms (Dogwood/Robin Court and Rosewood), 2 of 5 medication carts (Robin Court and Rosewood), and 2 of 3 treatment carts (Dogwood and Robin Court). Furthermore, the facility failed to ensure expired medications were disposed of for 2 of 2 medication rooms (Dogwood/Robin Court and Rosewood) and 1 of 3 (Dogwood) treatment carts. These practices had the potential to effect 46 of 62 residents residing in the facility.</p> <p>Findings include:</p> <p>During a medication storage observation on the Dogwood and Robin Court Units, beginning on 4/18/16 at 9:52 a.m., and accompanied by Unit Manager #2, the following were observed:</p> <p>In the medication room, the following was observed in the wall cabinet:</p> <p>1. A box containing 16 tablets of Zyrtec (allergy medication) 10 mg for Resident #149. The medication had expired March, 2016.</p>	F 0431	<p>WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were directly affected by this alleged practice HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Residents residing in the facility have the potential to be affected Expired medications have been removed. Medications without labels are now labeled correctly. There are checks made daily to assure these labels are written clearly. The nurses now check the incoming medications against the actual orders and the MAR to assure that if a medication has been discontinued we do not accept that medication from the pharmacy or we dispose of what was left of the medication. Medications are also stored in individual bags for each resident. The eye medications are not stored with the ear medications. Scissors are cleaned immediately after use and are not stored unless in a plastic bag Bandages are identified and stored correctly. House stock is now identified for each resident. Muscle rub is stored correctly. The Medication</p>	05/05/2016			

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	<p>2. A bottle containing 14 capsules of omeprazole (acid reflux) 20 mg for Resident #44. The label indicated the medication had been filled on 2/26/16 with a total quantity of 15 capsules.</p> <p>A bottle containing 30 tablets of lovastatin (cholesterol medication) 20 mg for Resident #44. The label indicated the medication had been filled on 2/26/16 with a total quantity of 30 tablets.</p> <p>Three packets, each containing four tablets of Fosamax (bone health) plus D 70/2800 mg for Resident #44. The label indicated the medication had been filled on 2/27/16.</p> <p>Review of Resident #44's clinical record on 4/19/16 at 2:05 p.m., indicated the Fosamax had been discontinued on 2/26/16, the lovastatin had been discontinued on 1/5/16, and the omeprazole had been discontinued on 11/19/15.</p> <p>Unit Manager #2 indicated, at the time of the observation, the medications in the cabinet had been discontinued and should have been destroyed. She identified 21 residents who might have been affected by this practice.</p> <p>3. Inside a plastic basket containing, but</p>		<p>rooms and the Medication and treatment carts area checked daily by the managers and every shift at shift change by each individual nurse. Denture tablets and packets of condiments are not stored in the medication or treatment carts WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: There are audit tools that have been developed for each nurse to check each cart (med and treatment) prior to taking over the shift There is also an audit tool for the managers to check the Medication rooms, carts and treatment carts on a daily basis. These audits will continue. If any issue is discovered, there will be disciplinary action taken immediately. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: There is a Performance Improvement Plan initiated for the Quality Assurance Committee to monitor This program will continue for at least one year. After one year, the Committee will decide whether to continue or discontinue the audits based on whether the audits are in 100% compliance for at least 6 months.</p>	

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	<p>not limited to, a pile of small plastic baggies and rubber bands, four, unlabeled, 1 ounce tubes of bacitracin ointment were observed. Three of the tubes had torn pieces of a blue label near the end of the them, one with "wrist" on the label, one with "tear on" the label, and one with "be" on the label. None of the four tubes were labeled with a resident identifier or instructions. Each tube of bacitracin was partially empty with part of the tube depressed.</p> <p>4. In the same cabinet, to the right of the plastic basket, an open bag containing twenty unit dose (3 milliliter) vials of albuterol 0.083% (bronchodilator) and a closed bag containing thirty unit dose vials of albuterol 0.083%, was observed. One 4 ounce tube of muscle rub was on the shelf in front of the albuterol. The writing on the back of the tube near the cap had been smeared and the tube was partially empty. The medications were not labeled or designated for any resident.</p> <p>An observation of the Dogwood Unit treatment cart, accompanied by Unit Manager #2, indicated the following:</p> <p>5. In the top drawer of the cart, one pair of angled bandage scissors were observed with a clear gel-like substance on the blade end. A pair of straight bandage</p>			

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	<p>scissors were observed with a clear gel-like substance on the blade end and a small piece of dark yellow woven material was stuck between the blades. A loose, 4 ounce tube of Calazime paste (skin protectant) with Resident #31's name was observed under the scissors. A 30 gram bottle of nystatin powder labeled for Resident #77 was next to the Calazime paste and scissors. An open 5 x 9 inch Xeroform dressing was observed under the Calazime paste.</p> <p>During the observation, the ADON walked past the cart and asked Unit Manager #2 why the scissors were being removed from the cart; the Unit Manager indicated it was because the scissors were "disgusting".</p> <p>6. In the second drawer of the cart, a 16 ounce jar of Eucerin cream was in a compartment with an open tube of Calazime ointment labeled with another resident's name. Neither the Eucerin cream nor the Calazime cream was in a bag or package separating them from the other.</p> <p>7. In the third drawer of the cart, two 8 ounce bottles of Anasep wound spray were observed in a large plastic storage bag. There was an orange-brown colored substance with a granulated texture that</p>			

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	<p>was thicker on the spray trigger and smeared downward to the neck of one bottle and smears of the substance on the trigger and neck of the other bottle. Two 4 ounce tubes of Calazime paste and one 2.47 ounce tube of skin protectant ointment, each labeled with Resident #151's name, were loose in the drawer.</p> <p>Unit Manager #2 indicated Resident #151 had been discharged from the facility the previous Friday.</p> <p>Review of Resident #151's clinical record, on 4/19/16, indicated she had been discharged from the facility on 4/13/2016.</p> <p>A package containing two, 6 x 6 inch Optifoam dressings for Resident #151 was observed in the fourth drawer of the cart.</p> <p>8. Two, 16 ounce bottles of Cetaphil lotion, with no resident identifiers, were also in the drawer. The Unit Manager was able to dispense lotion freely from one bottle. She indicated it was "house stock". One loose, 8 ounce bottle of no-rinse shampoo with no resident identifiers on it, with approximately 1/4 of the content left per Unit Manager #2, was next to the lotion bottles.</p>			

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	<p>An observation of the Robin Court treatment cart, accompanied by Unit Manager #2, indicated the following :</p> <p>9. Two, 8 ounce bottles of MicroKlenz antimicrobial wound cleanser, one un-opened and one with a small amount left in the bottle, were in the fourth drawer of the cart. A bottle of wound cleanser was next to the two bottles of MicroKlenz. None of the bottles were labeled with a resident identifier, nor were they separated in any manner from other items in the cart.</p> <p>An observation of the Robin Court medication cart, accompanied by Unit Manager #2, indicated the following:</p> <p>10. In the top drawer of the cart, to the right of the drawer divider, a saline nasal spray was stored with eye drops including, but not limited to, atropine , artificial tears, prednisolone, and Vigamox. Four, 4 ounce tubes of Calazime skin paste were stored with the eye drops and the saline nasal spray. One tube was marked with a resident's name on it, two tubes were unmarked and had charge stickers on them, and one was unmarked with the charge sticker removed. To the left of the drawer divider, earwax drops were stored with artificial tears.</p>			

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	<p>Unit Manager #2 indicated she was not aware of how often the medication room, medication carts, and treatment carts were cleaned on the Dogwood and Robin Court units. She identified 31 residents who potentially were affected by this practice.</p> <p>During a medication storage observation on the Rosewood Unit, beginning on 4/18/16 at 10:52 a.m., and accompanied by Unit Manager #3, the following were observed:</p> <p>In the medication room, the following was observed in the wall cabinet labeled for resident personal items:</p> <p>11. Two 4 ounce tubes of muscle rub were observed in a large plastic storage bag. Both tubes had torn pieces of a blue label on them, one with "to (B) knees as management" printed on it and the other printed with "to affected needed" on the piece of label.</p> <p>The Unit Manager #3 indicated the medications should not have been in the cabinet. She identified</p> <p>On 4/18/16 at 10:55 a.m., Unit Manager #2 indicated medication storage areas were cleaned three times weekly and as</p>			

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	<p>needed.</p> <p>An observation of the Rosewood medication cart for rooms 101-110 indicated the following:</p> <p>12. In the top drawer, a small basket containing batteries also contained, but was not limited to, 2 denture cleaner tablets, a ketchup packet, two mayonnaise packets, a mustard packet, two coffee creamer packets, a loose 3 cc syringe (without a needle), three loose Duoneb (breathing treatment) unit dose vials, two open wound closure strips, and a corner of an unpackaged adhesive padded dressing. A divider section of the drawer contained an unmarked Blistex lip balm, which was rounded in shape when opened by the unit manager, and an unmarked tube of mouth moisturizer.</p> <p>Unit Manager #3 indicated the mouth moisturizer was "house stock", although she she could not indicate who it belonged to or whether or not it had been used.</p> <p>13. A loose packet labeled as Spiriva (breathing treatment)18 mcg was observed loose in the third drawer of the cart. A loose Duoneb unit dose vial was loose in the drawer. A Spiriva Handihaler was laying loose and</p>			

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	<p>uncovered in the drawer.</p> <p>Unit Manager #3 indicated, during the observation, the medication storage areas were cleaned by night shift and audited by the unit manager three times a week and more often as time allowed.</p> <p>On 4/18/16 at 11:39 a.m., the Administrator and ADON indicated the nursing staff had been inserviced regarding proper medication storage following the annual survey.</p> <p>On 4/18/16 at 2:21 p.m., the Administrator indicated the nurse managers were supposed to be auditing the medication storage areas.</p> <p>Review of the facility plan of correction, dated as completed on 3/9/16, indicated the following: "WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: An audit tool has been developed to assist management in monitoring the cleanliness of the medication/treatment carts, the accuracy of the medications located in the carts, comingling of any medications, and storage in the medication room . All nurses were re-educated on 3/8/16</p>			

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	<p>regarding the cleanliness, storage, labeling and comingling of medications. This audit tool will be utilized 3 X's weekly."</p> <p>Review of a Drug Storage Inservice, dated 3/4/16, and provided by the DON on 4/19/16 at 11:11 a.m., indicated the following:</p> <p>"...A cleaning schedule will be put in place by the D.O.N. of the medication carts...weekly cleaning...Expired and discontinued medications and treatments will be removed from the carts and disposed of...No food items of any kind can be stored in the med carts...</p> <p>...MED ROOMS: Staff and resident medications cannot be stored together. Any discontinued/Expired medications must be destroyed of by returning to pharmacy or destroying...."</p> <p>Review of a document, titled, "...MED/TX CARTs CLEANING SCHEDULE..." indicated the following:</p> <p>"...DOGWOOD: Tuesday Med cart 201-212, Wednesday Tx cart, Thursday #213-222, Saturday Med Cart #301-310...</p> <p>...Rosewood: Tuesday Med Cart #101-112, Wednesday Tx Cart, Thursday</p>			

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	<p>Med Cart #113-120...</p> <p>...Cleaning of MED/TX CARTS...</p> <p>...4] Check for any/all expired meds/txs. Remove them from the cart and re-order them or list them on Resident's Drug Destruction Form and follow the proper procedure for destroying medications...</p> <p>...5] Remove soiled plastic bags, eye/ear drops inhalers, nose sprays, etc. Replace with clean bags (and/or clean med containers) as needed to separate these medications into separate bags (even if in boxes)...."</p> <p>Review of "Medication Audits" for the dates of March 12 through April 14, 2016, indicated unlabeled and expired medications were found in medication carts and medication rooms on the following dates: 3/12, 3/13, 3/14, 3/16, and 4/8.</p> <p>Continued review of the "Medication Audits" indicated treatments for a discharged resident were removed from the medication room on 3/21. The audit further indicated medications from discharged residents were removed from the medication cart on 3/25 and 3/28.</p> <p>The "Medication Audits" further</p>			

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	<p>indicated on 3/1 open packs of Xeroform and Optifoam (wound dressings) were removed from a treatment cart and "someone keeps putting crackers in Tx [treatment] carts!".</p> <p>On 4/19/16 at 11:11 a.m., the DON indicated the facility nurses had been inserviced thoroughly following the annual survey and the unit managers had assured her, as of the previous Friday, that everything "had looked good". She further indicated breaks in medication storage policy should have been found during the audits completed by the nurse managers three times a week. When questioned about how issues were corrected when problems were identified during the medication storage audits, the DON indicated disciplinary action should have taken place to ensure the error was not repeated. The DON further indicated she was not aware of any disciplinary action occurring related to the medication storage audits when specifically asked about 3/12 and 3/13. She also indicated she looked through the audits herself after the forms were placed in the plan of correction binder in her office.</p> <p>3.1-25(o) 3.1-25(p) 3.1-25(r)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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(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
R 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the State Licensure Survey completed on April 19, 2016.</p> <p>Survey dates: April 18 and 19 2016</p> <p>Residential Census: 22</p> <p>Sample: 1</p> <p>Monticello House was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Licensure Survey.</p> <p>QR completed by 11474 on April 20, 2016</p>	R 0000	<p>This Plan of Correction constitutes the written allegation of compliance for deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.</p>	