

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2014
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NAME OF PROVIDER OR SUPPLIER CORE OF DALE	STREET ADDRESS, CITY, STATE, ZIP CODE 510 W MEDCALF ROAD DALE, IN 47523
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00156660.</p> <p>Complaint Number IN00156660-Substantiated.</p> <p>Federal/State deficiencies related to the allegations are cited at F223, F225, F226, F314, and F465.</p> <p>Survey dates: October 22, 23, 24, 27, 28, and 29, 2014</p> <p>Survey Team: Terri Walters RN-TC 10/22,23,27,28,29/14 Dorothy Watts RN 10/22,23,27,28,29/14 Amy Wininger RN 10/22,27,28,29/14 Sylvia Scales RN 10/23,24,27,28,29/14</p> <p>Facility number: 000170 Provider number: 155270 AIM number: 100287490</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census payor type: Medicare: 3 Medicaid: 38</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or of conclusions set forth on the statement of deficiencies. This Plan of Correction is prepared and executed solely because it is required by Federal and state law. This Plan of Correction is submitted in order to respond to the allegations of non-compliance during complaint/Annual survey review concluding on 10/29/2014. Please accept this Plan of Correction as the provider's credible aggregation of compliance effective 11/28/2014. We respectfully request a desk review for compliance.</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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F000223 SS=D	<p>Other: 6 Total: 47</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed on November 6, 2014 by Jodi Meyer, RN</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure residents were free of physical and psychological abuse for 1 of 7 residents reviewed for abuse, in that, a Certified Nursing Assistant (CNA) covered a residents mouth with her hand to stop her from screaming. (Resident L)</p> <p>Findings include:</p> <p>On 10/24/14 at 1:32 P.M., the facilities reportable incidents were reviewed. An</p>	F000223	F223 Resident L suffered no ill effects from the alleged deficient practice. CNA#20, NA#2 are no longer employed at this facility. DON was informed on 4/10/14 at 12:20AM of alleged incident that had occurred 3 hours prior to report. DON immediately investigated upon receiving report and determined allegation substantiated. DON immediately called CNA #20 and left message on phone to return the call and not return to work due to suspension. CNA #20 was officially terminated later that	11/28/2014			

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	<p>undated "FAX/ INCIDENT REPORT" contained an incident involving Resident L and CNA #20 and Nursing Assistant (NA) #2. The allegation of abuse was reported to the Director of Nursing (DON) on 4/10/14 at 12:20 A.M. by NA #2. The report indicated that on 4/9/14 at 9:00 P.M., CNA #20 and NA #2 were assisting Resident L to bed. NA #2 reported Resident L began to scream and CNA#20 placed her hand over Resident L's mouth to muffle her yells.</p> <p>During an interview on 10/27/14 at 10:30 A.M., the Director of Nursing (DON) indicated an allegation of abuse was reported to her on 4/10/14 at 12:20 A.M. The DON indicated she was in her office and NA #2 came in and reported that on 4/9/14 at 9:00 A.M., she was assisting CNA #20 put resident L to bed and when Resident L began to scream CNA #20 placed her hand over her mouth to "muffle" the sounds. She further indicated she had interviewed Resident L immediately. She indicated Resident L reported no other incidents with CNA #20 but indicated she felt CNA #20 was "trying to kill her." She indicated CNA #20 had finished her shift already and was gone for the evening and she could</p>		<p>morning upon her return call and DON reported incident to the ISDH. All residents have the potential to be affected and therefore by re-education and in-services the facility will ensure that residents are free of any forms of abuse. Systemic Changes will be that a Quarterly ALL STAFF In-service will be held on "Staff Burn-out" and "Effective Coping Skills for the management of Behaviors in Long Term Care". DON/Designee will interview 2 random residents, utilizing the QIS Survey tool for Abuse, 5 times/weekly for 1 month, 3 times a week for 1 month then weekly for 6 months and quarterly thereafter with results forwarded to the QA committee for review and further suggestions/comments. This monitoring and quarterly in-servicing will be ongoing due to the nature of deficiency and CORES dedication to provide the highest quality of care to our residents while being supportive to our staff thru re-education and collaboration.</p>				

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F000225 SS=D	<p>not reach anyone for interview that evening so she waited to report the incident to the Indiana State Department of Health until it was complete. She indicated the investigation was substantiated.</p> <p>This Federal tag relates to Complaint IN00156660.</p> <p>3.1-27(a) (1)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all</p>						

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	<p>alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported timely to the facility administration and/or to the Indiana State Department of Health, in that, a Nursing assistant who witnessed physical abuse did not immediately report the incident to her supervisor, and/or after an allegation of abuse was reported the facility did not immediately report the incident to the Indiana State Department of Health. (Resident L)</p> <p>Findings include:</p> <p>1. On 10/24/14 at 1:32 P.M., An undated, untimed " FAX/ INCIDENT REPORT" was reviewed. It included the initial report with follow up for an allegation of abuse that occurred on 4/9/14 at 9:00 P.M., involving Resident L and Certified Nursing Assistant #20 and Nursing</p>	F000225	F225 Resident L suffered no ill effects from the alleged deficient practice. CNA #20, NA #2 are no longer employed at this facility. DON was informed on 4/10/14 at 12:20am of the incident that had occurred 3 hours prior to report. DON immediately investigated incident and determined that allegation substantiated. DON terminated CNA #20 and reported incident to the ISDH. All residents have the potential to be affected and thereforeby re-education and in-services regarding updated Abuse Policy and Procedures,the facility will ensure that residents are free of any forms of abuse. Systemic Changes will be that we will increase our Abuse Policy In-services to Quarterly for all staff. And update current Abuse Policy to include "... All allegations of abuse are to be reported immediately to charge nurse,immediately to Administrator/Designee.....and	11/28/2014			

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	<p>Assistant #2. The allegation was reported on 4/10/14 at 12:20 A.M. (3 hours and 20 minutes after incident occurred) to the Director of Nursing (DON) by NA #2. NA #2 indicated while she and CNA #20 were assisting Resident L to bed, Resident L began to scream, she further indicated CNA#20 placed her hand over Resident L's mouth to muffle her yells. Following the complete investigation of the allegation it was substantiated and CNA #20 was terminated. The fax confirmation sheet attached to the document indicated the document including the initial report and completed investigation was sent to the Indiana State Department of Health on "4/10/14 at 13:53" (1:53 P.M.).</p> <p>2. During an interview with the DON on 10/27/14 at 10:30 A.M., she indicated on 4/10/14 at 12:20 A.M., she was in her office and NA #2 came to her office and reported an allegation of abuse that had occurred on the prior shift involving Resident L. She indicated NA #2 had reported that CNA #20 had placed her hand over Resident L ' s mouth to stop her from screaming so loudly. She indicated she took the report and then immediately went to talk to Resident L who reported that she felt CNA #20 was</p>		<p>immediately to ISHD.....". DON/Designee will complete a quiz on 2 random employees to assure understanding of the Abuse Policy and Reporting requirements to be done 5 times weekly for 1 month, then 3 times weekly for one month, then weekly for the next 6 months and quarterly thereafter on an on-going basis. All results will be forward to the QA committee for further suggestions/comments.</p>				

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	<p>" trying to kill her." The DON further indicated that CNA #20 was terminated and all other staff were in-serviced including abuse, stress management, behavior management and inappropriate staff behavior and reporting requirements. She indicated all staff were to report any allegations of abuse to a supervisor immediately. She indicated she had reported the allegation to the Indiana State Department of Health on 4/10/14 at 1:53 P.M. because at that time the policy indicated she had 24 hours to report.</p> <p>3. The facility provided a policy titled " ABUSE AND UNUSUAL OCCURRENCE DEFINED AND POLICY " dated August 30, 2013 on 10/24/14. It included " ...Physical Abuse-including but is not limited to hitting, pinching, slapping, any form of physical punishment ... " It also included " ...All incidents and <u>all allegations</u> to the Administrator or Director of Nursing within <u>ONE Hour</u>. If you are unsure if an incident is reportable, then it is your responsibility to report immediately to your Supervisor/Department Head/Charge Nurse, and it will be their</p>						

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F000226 SS=E	<p>responsibility to report and clarify with Administrator or Director of Nursing. This Federal tag relates to Complaint IN00156660.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>B. The Employee Files were reviewed on 10/29/14 at 2:00 P.M. and the following was noted:</p> <p>B. 1. RN #1: RN #50 who maintained employee files verified RN#1's hire date was 04/07/14. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 04/14/14. (7 days)</p> <p>B. 2. LPN #2: RN #50 who maintained employee files verified LPN # 2's hire date was 04/07/14. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 04/11/14. (5 days)</p> <p>B. 3. QMA #3: RN #50 who maintained employee files verified QMA</p>	F000226	F226 Resident L suffered no ill effects from the alleged deficient practice. CNA #20, NA #2 are no longer employed at this facility. DON was informed on 4/10/14 at 12:20AM of incident that had occurred 3 hours prior to report. DON immediately investigated the incident and determined that allegation was substantiated. DON terminated CNA #20 and reported incident to the ISDH. RN #1, LPN#2, QMA#3, CNA#4,CNA#5, HK#6 are all found to have clean criminal background Histories. All residents have the potential to be affected and therefore by re-education and in-services the facility will ensure that residents are free of any forms of abuse. All employees' personal records audited to assure that criminal background checks reviewed for completion. Systemic Changes	11/28/2014

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	<p>#3's hire date was 01/10/14. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 01/28/14. (18 days)</p> <p>B. 4. CNA #4: RN #50 who maintained employee files verified CNA #4's hire date was 6/19/14. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 07/03/14. (14 days)</p> <p>B. 5. CNA #5: RN #50 who maintained employee files verified CNA #5's hire date was 09/30/14. RN #50 indicated a criminal background check had not been requested.</p> <p>B. 6. HK #6: RN #50 who maintained employee files verified HK #6's hire date was 06/15/13. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 06/28/13. (13 days)</p> <p>During an interview on 10/29/13 at 2:40 P.M., RN #50 indicated she did not realize the criminal background checks for new employees should be completed before new hires begin work.</p> <p>The Policy and Procedure for Abuse Prohibition, Reporting and Investigating was provided by the Director of Nursing</p>		<p>will be that we will increase our Abuse Policy In-services to quarterly for all staff, And updated current Abuse Policy to include ".... All allegations of abuse are to be reported immediately to Administration/DONwho is to immediately report allegation to ISHD....." Systemic changes will be that all employees will have criminal background checks returned and reviewed before they begin working on the floor. Abuse policy updated to include this change. DON/Designee will interview 2 random residents utilizing the QIS Survey tool for Abuse 5 times/weekly for 1 month, 3 times/week for 1 month then weekly for 6 months and will continue quarterly and be on-going with results forwarded to the QA committee thereafter for review and further suggestions/comments. Staff Development Coordinator/Designee will review all new hires to assure that criminal background checks are completed prior to working the floor this will be audited 5 times weekly for 1 month, then 3 times weekly for one month, then weekly for 6 months with results forwarded to the QA committee for further suggestions/comments.</p>				

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F000282 SS=D	<p>on 10/29/14 at 2:30 P.M. The Policy and procedure lacked any documentation concerning the requirement that a criminal background check must be completed prior to new hires beginning work.</p> <p>This Federal tag relates to Complaint IN00156660.</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(b)(1)(A)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the physician's orders, in that, an antibiotic medication was not administered as ordered by the physician for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #53)</p> <p>Findings include:</p> <p>Resident #53 was observed on 10/22/14 at 9:15 A.M., to be restless and</p>	F000282	F282 Resident #53 suffered no ill effects from the alleged deficiency. All residents have the potential to be affected by the alleged deficiency. All residents currently on antibiotics have been reviewed to assure medication administered as per physician's orders. Nursing staff have been in-serviced on medication administration and Antibiotic/Infection Count Forms. Systemic change implemented to correct this alleged deficiency are that antibiotics will be logged on a New Form. Antibiotic/Infection numbered count form. Don/ Designee will perform audits of 3	11/28/2014			

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	<p>repeatedly attempting to exit the bed independently and stated, at that time, "...I have to go, I have to go..."</p> <p>The clinical record of Resident #53 was reviewed on 10/27/14 at 12:00 P.M. The record indicated the diagnoses of Resident #53 included, but were not limited to, chronic urinary tract infection.</p> <p>The Admission MDS (Minimum Data Set) Assessment dated 09/12/14 indicated Resident #53 experienced severe cognitive impairment, and/or constant urinary incontinence.</p> <p>A Physician's telephone order dated 10/13/14 included an order for, "...Trimethoprim (an antibiotic) 100 mg (milligram) po (by mouth) daily for UTI (urinary tract infection) prophylaxis (prevention)..."</p> <p>A Care Plan dated 10/04/14 for Chronic UTI included, but was not limited to, an intervention of, "...meds (medicines) A/O (as ordered)..."</p> <p>The October MAR (Medication Administration Record) 2014 indicated Resident #53 did not receive Trimethoprim as ordered on October 25, and 26, 2014. During an interview on 10/27/14 at 9:00 A.M., QMA (Qualified</p>		<p>random residents to assure that Antibiotic/Infection forms completed 5 times/weekly for 1 month, 3 times a week for 1 month then weekly for 6 months and quarterly thereafter with results forwarded to the QA committee for review and further suggestions/comments.</p>				

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F000314 SS=D	<p>Medication Assistant) #1 indicated 30 doses of the antibiotic had been delivered on 10/15/14 and 12 doses should have been administered. QMA #1 further indicated, at that time, the medication supply had been counted and 22 doses of the antibiotic remained. QMA #1 then indicated 8 doses had been administered.</p> <p>During an interview with on 10/28/14 at 9:00 A.M., the DON (Director of Nursing) indicated Resident #53 missed 4 doses of the ordered antibiotic. The DON then indicated the antibiotic should have been administered as ordered by the physician.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, interview, and record review, the facility failed to ensure pressure sores were identified correctly and/or treatments were provided to</p>	F000314	F314 Resident A no longer resides at Nursing Facility All residents have the potential to be affected by the alleged deficient practice and through alterations in	11/28/2014			

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	<p>prevent worsening, in that, documentation was lacking to show skin assessments were completed and treatments provided for a resident who was admitted to hospital with multiple areas of pressure. (Resident A)</p> <p>Findings include:</p> <p>On 10/22/14 at 10:20 A.M., Resident A was observed lying in bed with eyes closed.</p> <p>The clinical record for Resident A was reviewed on 10/24/14 at 5:23 A.M., diagnoses included, but were not limited to congestive heart failure, dementia, and diabetes mellitus type 2.</p> <p>A nursing note dated 8/27/14 at 10 P.M., indicated resident had a red area measuring 1.2 centimeters (cm) by 1 cm noted on right inner buttock. Documentation of further assessment of that area and/or treatment was lacking.</p> <p>An untimed "Patient Transfer Form" dated 8/28/14 lacked any documentation of skin impairments.</p> <p>An untimed skin assessment sheet dated 8/28/14 indicated the Resident A had no new areas of skin impairment noted.</p>		<p>processes and in-services the Health facility will ensure measures to prevent the development of new pressure ulcers and provide care for current pressure areas in accordance with physician orders. Skin assessments have been completed on all residents in the nursing facility. All nursing staff has been in-serviced on Completing a thorough skin assessment and documentation of skin impairments on the proper forms. Nursing staff have also been in-service on importance of documenting skin condition upon discharge to the hospital. Systemic changes are that Skin assessments will be completed prior to transfer to hospital and documented. In addition to our current facility transfer report, the transferring nurse will include a report of Skin Condition at time of discharge to receiving facility nurse. The names of nurse giving report and the nurse receiving the report will be added to discharge documentation. Don/ Designee will perform audits of discharged resident documentation and 3 random residents to assure that Skin Assessments were completed and treatments provided 5 times/weekly for 1 month, 3 times a week for 1 month then weekly for 6 months and quarterly thereafter with results forwarded to the QA committee for review and further</p>		

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	<p>Resident A's clinical record was reviewed at the local hospital on 10/27/14 at 12:30 P.M. An Acute Care admission physical (hospital admission assessment) dated 8/28/14 at 2100 (9:00 P.M.) included a skin assessment on admission for Resident A.</p> <p>Pressure areas listed included:</p> <p>Area 1. A suspected deep tissue injury, (a pressure area where skin remains intact and tissue under the surface is damage) on the right heel, measuring 4.0 cm by 1.5 cm.</p> <p>Area 2. An unstagable pressure area (an open pressure wound where the base was covered with slough making viewing the wound bed difficult) to right posterior buttock measuring 1.2 cm by 1.0 cm, area had a scant amount of drainage and wound bed was assessed to contain white and yellow slough (necrotic tissue separating from the body) with undermining (deep tissue damage around the wound margins).</p> <p>Area 3. A stage 3 pressure area (an open area of pressure with damage below the skin) around the suprapubic catheter insertion cite, measuring 0.5 x 1.0 cm with a depth of 0.5 cm.</p> <p>During an interview with the DON on 10/29/14 at 11:50 A.M., she indicated</p>		<p>suggestions/comments. This monitoring and quarterly in-servicing will be ongoing due to the nature of deficiency and CORES dedication to provide the highest quality of care to our residents.</p>				

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F000323 SS=E	<p>Resident A was sent to the local hospital on 8/28/14 she indicated an assessment was complete indicating Resident A had "no new skin areas". She indicated at that time they were treating an area to Resident A's buttock with lanaseptic (a skin protectant cream). She indicated on 8/27/14 Resident A's heels were red and mushy and they had received an order for heel lift boots that day. She confirmed documentation of those areas were lacking in the clinical record.</p> <p>The facility provided a policy dated 7/1/14 titled " CORE NURSING WEEKLY SKIN ASSESSMENT GUIDELINES" on 10/28/14 at 12:44 P.M., it included " ... 4. The nurse completing the weekly skin check shall indicate all skin issues which are found to exist on the resident. Measurements are made and transferred to appropriate tracking form..."</p> <p>This Federal tag relates to Complaint IN00156660.</p> <p>3.1-40 (a) (1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>						

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	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure a resident identified as a high risk to fall received adequate supervision and/or failed to ensure interventions were implemented, in that, a resident identified as a high risk to experience a fall was not provided with adequate supervision during periods of restlessness. (Resident #53)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure side rails were maintained in the correct position and/or were installed per the manufacturer's instructions for 6 of 47 resident beds in the facility. (Resident #3, Resident #36, Resident #25, Resident #52, Resident #40, Resident #13)</p> <p>Findings include:</p> <p>A. Resident #53 was observed on 10/22/14 at 9:15 A.M. to be restless and repeatedly attempting to exit the bed independently and stated, at that time, "...I have to go, I have to go..."</p> <p>The clinical record of Resident #53 was</p>	F000323	F323 Resident #53 no longer resides at the facility, but interventions of PVC floor level bed with floor Mat at bedside were implemented. Resident #3, #36, #25, #52, #40, #13 side rails applied per manufacturer's recommendations. All other residents have the potential to be affected by the alleged deficiency and through alterations and processes and in-servicing the facility will ensure that the residents environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistive devices to prevent accidents. All residents accident interventions CarePlans have been reviewed to ensure individualized interventions are appropriate and realistic. All side rails in the facility audited by maintenance to ensure proper installment and function. Nursing staff have been in-serviced concerning fall safety management and immediate interventions implementation. Nursing staff have been in-serviced on maintenance work orders for any concerns with loose/unsafe equipment. Maintenance workers have received proper training on installation of bed rails. Systemic	11/28/2014

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	<p>reviewed on 10/27/14 at 12:00 P.M. The record indicated the diagnoses of Resident #53 included, but were not limited to, dementia with behaviors, Bell's palsy, and chronic urinary tract infection.</p> <p>The Admission MDS (Minimum Data Set) Assessment dated 09/12/14 indicated Resident #53 experienced severe cognitive impairment, unsteadiness during walking and transitions, and/or had a history of falls.</p> <p>The Admission Physicians' Orders dated 09/05/14 included, but were not limited to, orders for, "...use seatbelt alarm in w/c [wheelchair]...bed pad alarm..."</p> <p>The Plan of Care for Falls dated 09/05/14 included, but was not limited to interventions of, "...monitor at nursing station during periods of increased agitation, restlessness..."</p> <p>A Fall Risk Assessment dated 09/21/14 indicated Resident #53 was a high risk to experience a fall.</p> <p>Fall #1 A nursing note dated 10/11/14 at 6:10 P.M., indicated Resident #53 experienced a fall. The nursing note further indicated, "...was sitting in the east lounge area at</p>		<p>change will be that with Falls/Accidents the nurse will be required to conference/collaborate with another employee at the time of the fall, to coordinate immediate and appropriate interventions. Maintenance will monitor and complete quarterly audits of side rails to ensure that they are functioning safe according to Manufacturer recommended guidelines DON/ Designee will Audits 3 random residents at risk for falls to assure safety interventions implemented and adequate supervision to prevent falls, this will be done 5 times/weekly for 1 month, 3 times a week for 1 month then weekly for 6 months and quarterly thereafter with results forwarded to the QA committee for review and further suggestions/comments. This monitoring will then become ongoing on quarterly schedule. Maintenance Supervisor/Designee will Audit 3 random resident side rails to ensure proper functioning/installation 5 times weekly for 1 month, then 3 times weekly for one month, then weekly for 6 months with results forwarded to the QA committee for further suggestions/comments. This quarterly monitoring and QA reporting will become ongoing.</p>		

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	<p>the table...Res [resident] flipped her w/c backwards...no apparent new injuries..."</p> <p>During an interview on 10/28/14 at 12:07 P.M., the DON (Director of Nursing) indicated, the resident was sitting in the lounge across from the nurse's station and the nurse's were seated behind the nurse's station at the time of the fall. The DON then stated, "...they looked away...they just couldn't get there in time..."</p> <p>Fall #2 A nursing note dated 10/21/14 at 9:00 P.M., indicated Resident #53 experienced a fall. The nursing note further indicated, "...Res scooted out of bed while I was getting the aide to help me put res in w/c...Res was pulled up in bed several mins (minutes) before..."</p> <p>During an interview on 10/28/14 at 12:10 P.M., the DON indicated, the resident had been left alone while a staff member went to look for assistance.</p> <p>Fall #3 A nursing note dated 10/27/14 at 5:00 P.M., indicated, "...Pt. (patient) up in Broda chair (a tilt/positioning chair) continuously restless..." A nursing note dated 10/27/14 at 6:00 P.M., indicated, "...Pt. put back to bed, bed alarm on..."</p>						

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	<p>A nursing note dated 10/27/14 at 8:00 P.M., indicated, "...Pt is frequently setting the alarm, Pt is redirected back to lay down..."</p> <p>A nursing note dated 10/27/14 at 9:00 P.M., indicated, "...Pt alarm is again going, Pt checked and found on her bottom sitting on the floor, No witness to event..."</p> <p>A nursing note dated 10/27/14 at 10:30 P.M., indicated, "...Pt is up at the nurses's desk in her w/c..."</p> <p>During an interview on 10/28/14 at 12:12 P.M., the DON indicated, Resident #53 was not brought to the nursing station for monitoring during an episode of restlessness because the nurse was passing medication.</p> <p>The policy and procedure for Falls provided by the DON on 10/30/14 at 2:44 A.M., indicated, "...Care Plan Interventions for Falls...bring to supervised area for closer supervision..."</p> <p>B. 1. On 10/23/14 at 9:30 A.M., in room 216, Resident #36's bed was observed to have bilateral side rails. The side rail closest to the room door was leaning in toward the bed frame. The side rail was loose and moved a couple of inches in and out toward the bed frame when it was gripped. The Housekeeping Supervisor</p>						

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	<p>was made aware at that time of the side rail loosely attached to the bed and not positioned correctly with movement noted. The Housekeeping Supervisor agreed and tried to tighten the rail by tightening a knob on the rail. She was unable to tighten the side rail or to correct the position of the rail. She also checked the other side rail and indicated it was loosely attached also. The Housekeeping Supervisor indicated she would notify the maintenance staff regarding the loosely fitting side rails.</p> <p>B. 2. On 10/23/14 at 10:10 A.M., in room 214, Resident #3's bed was observed to have bilateral side rails. The Housekeeping supervisor and the Therapy Director were made aware of the bed side rail facing the room door moved loosely from side to side when grasped. The Therapy Director and the Housekeeping Supervisor agreed the side rail moved loosely from the bed and at that time examined the mattress and the bed frame to identify how the side rails had been attached to the bed.</p> <p>B. 3. On 10/23/14 at 11:00 A.M., the Therapy Director and the Housekeeping Supervisor provided documentation entitled, "Half Bed Rails" model number 6630.</p>			

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	<p>On 10/23/14 at 11:07 A.M., during interview with the Therapy Director, the Therapy Director indicated the facility had bought new beds from a supplier and the supplier had set up one of the new beds for the facility to use as a sample when assembling the new beds purchased. The Therapy Director indicated the crossbrace channel of the side rails had been applied incorrectly to the bed. He indicated the maintenance staff was going through out the building and correcting the position of the side rails on all the new beds of the facility.</p> <p>On 10/23/14 at 11:10 A.M., the Housekeeping Supervisor demonstrated that the side rails of Resident #36's bed were not loose and were in the correct position (not leaning toward the bed frame).</p> <p>Maintenance staff #1 was interviewed on 10/23/14 at 11:12 A.M., regarding side rail positioning. He indicated he had installed the crossbranch channel part of the bed rails upside down on the new beds the facility had purchased. He indicated he was now was going to correct the positioning of the crossbrace channel of the side rails.</p> <p>B. 4. On 10/23/14 at 10:19 A.M., the The Health Facility Administrator (HFA)</p>						

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F000329	<p>and the Director of Nursing (DON) were made aware of side rails of newer beds moving loosely from side to side. They were made aware in room 105, the bed of Resident #40 had side rails loosely attached and moved laterally when grasped.</p> <p>B. 5. On 10/23/14 at 11:41 A.M., during interviewing with the Housekeeping Supervisor she indicated when the facility purchased the new beds the company had assembled the first bed and had assembled the side rails incorrectly. Maintenance staff #1 had then assembled the rest of the new beds after the assembled 1st one. She indicated Maintenance staff #1 had been inserviced on correctly installing side rails and was now correcting the side rails placement and checking all beds in facility.</p> <p>On 10/23/14 at 11:50 A.M., the Housekeeping Supervisor provided a list of room with the new beds in which the side rails had been installed wrong, the list included but was not limited to: (Rooms: 208, 203,108, and 105).</p> <p>3.1-45(a)(1) 3.1-45(a)(2) 483.25(l)</p>						

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SS=D	<p>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 observation, interview, and record review, the facility failed to ensure medications were clinically indicated, in that, an as needed antipsychotic medication was administered without clinical indications being exhibited for 1 of 5 residents (Resident #53), non-pharmacologic interventions were not attempted before the administration of an as needed anti-anxiety medication for 1 of 5 residents (Resident #53), and/or annual attempts were not made to reduce or continue antipsychotic and/or</p>	F000329	F329 It is the policy of the facility to ensure each resident's drug regimen be free from unnecessary drugs. The facility will administer PRN psychotropic medications only after other interventions have been attempted and failed and only if necessary to protect the health, safety and welfare of residents in the facility. The facility will ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is	11/28/2014	

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	<p>psychotropic medications for 2 of 5 residents (Resident #34, Resident #10) who met the criteria for review of unnecessary medications.</p> <p>Findings include:</p> <p>1. Resident #53 was observed on 10/22/14 at 9:15 A.M., to be restless and repeatedly attempting to exit the bed independently and stated, at that time, "...I have to go, I have to go..."</p> <p>The clinical record of Resident #53 was reviewed on 10/27/14 at 12:00 P.M. The record indicated the diagnoses of Resident #53 included, but were not limited to, dementia with disturbance of behavior and mood.</p> <p>The Admission MDS (Minimum Data Set) Assessment dated 09/12/14 indicated Resident #53 experienced severe cognitive impairment.</p> <p>A Care Plan for Mood and Behavior dated 09/09/14 included, but was not limited to, "...Assess needs..."</p> <p>A. The Physician's Admission orders dated 09/05/14 included, but was not limited to, an order for, "...Zyprexa (an anti-psychotic medication) 10 mg (milligrams) IM (intramuscular) sol</p>		<p>necessary to treat a specific condition as diagnosed, and the residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions.</p> <p><u>Affected Resident</u> Resident # 53 was reviewed with the psychologist other condition and her behavior and mood. Reviewed her use of the PRN Klonopin and the restlessness and her current medical issues. Psychologist reviewed that she was on the Klonopin at admission and he recommended to put the Klonopin back to routine. Primary gave the order for Klonopin to return to routine. The recommendations from primary and the psychologist were to monitor for lethargy and improvement in her behavior and restlessness and re-evaluate her medications with her clear of infection. Resident # 34 and #10 will be reviewed at the Behavior Management Meeting on 11/13/2014 with the IDT and Pharmacy Consult to discuss their current antipsychotic medications to make a recommendation for a reduction in their medicine to be reviewed with their physician. <u>Other Residents</u> All other residents that are on PRN Psychotropic medications the</p>				

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	<p>(solution), 0.25 vial (2.5 mg), as needed q (every) 12 hours IM -if refuses PO meds..."</p> <p>The October 2014 MAR (Medication Administration Record) indicated Resident #53 received Zyprexa 2.5 mg IM on 10/23/14, 10/24/14, and 10/27/14.</p> <p>The October 2014 Nurse's Medication Notes indicated Resident #53 was administered Zyprexa 2.5 mg IM as follows:</p> <p>"...10/23/14... 0800 (8:00 A.M.)...refused meds..." The October 2014 MAR lacked any documentation medications had been refused at that time.</p> <p>"...10/24/14...0915 (9:15 A.M.)...restlessness..."</p> <p>"...10/27/14...0655 (6:55 A.M.)...ref (refused) po, agitated see NN (nurse's notes)..." The October 2014 MAR lacked any documentation medications had been refused at that time.</p> <p>A nurse's note dated 10/27/14 at 6:55 A.M. indicated, "...took PRN Klonopin with much encouragement..."</p> <p>B. A Physician's telephone order dated 09/17/14 included, but was not limited to, an order for, "...Clonazepam (Klonopin)</p>		<p>Nurses will report every time a PRN is given to the DON/SSD by completing the PRN usage form and SSD will review the chart for charting of thenon-pharmacological interventions with the results of the PRN that was used. All residents that are currently on a PRN psychotropic will be reviewed for frequency and the need for the PRN at theBehavior Management Meeting on 11/13/2014. All other residents that are on psychotropic medication will be reviewed at the Behavior Management Meeting for recommendations for medication reductions with the IDT and the pharmacy consult to be submitted to the physician for approval or denial for continuous or for reduction. <u>Systematic Change</u> The nurses are completing the PRN Psychotropic form every time a resident receives a PRN to report to SSD/DON. The form includes the time of the behavior, the assessment done , the interventions that the nurseand aides have done before administering a PRN. Social Services will track the PRN usage and follow up and review the chart for the non-pharmacological interventions used and the results of the PRN</p>				

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	<p>(an anti-anxiety medication) 1 mg po tid (three times daily) prn (as needed) for restlessness..."</p> <p>The October 2014 MAR and/or Nurse's Medication Notes indicated Resident #53 was administered Klonopin 1.0 mg as follows:</p> <p>"...10/07/14...1830 (6:30 P.M.)...restlessness..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>"...10/09/14...1730 (5:30 P.M.)...restlessness..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>"...10/14/14...0800 (8:00 A.M.)...restlessness..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>"...10/15/14...2230 (10:30 P.M.)...restlessness..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>"...10/18/14...2300 (11:00 P.M.)...restless..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p>		<p>psychotropic. Social Services will review with the DON on the charting. A weekly audit of the MAR's will be done to make sure all PRN's that were given were reported for 6 months and then 2 times per month for six months, then 1 time per month continuously.</p> <p>Every month at the Behavior management meeting all residents on a PRN Psychotropic will be reviewed for frequency and need of that PRN with the IDT and Pharmacy Consult. The policies are reviewed and revised to address the reporting of behavior, charting, and giving PRN psychotropic medications. Thenew form "PRN usage" was implemented on11/3/2014 to the nursing staff. All Nurses in-serviced on the policies andprocedures of charting and giving PRN psychotropic medications. The Behavior Management Meeting will continue to occur every month and each resident reviewed on a quarterly basis of their psychotropic medications. The IDT members and the Pharmacy consult will attend this meeting so the pharmacy recommendation can be completed and submitted to their primary physician for review. <u>Quality Assurance All</u></p>				

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	<p>"...10/21/14...1820 (6:20 P.M.)...restlessness..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>"...10/22/14...0830 (8:30 A.M.)...restless..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>"...10/25/14...1000 (10:00 A.M.)...restless..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>A nurse's note dated 10/06/14 at 1400 (2:00 P.M.) indicated, "...was restless today...received...Klonopin..." The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>The nurse's notes dated 10/07/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the anti-anxiety medication at 6:30 P.M..</p> <p>The nurse's notes dated 10/09/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the anti-anxiety</p>		<p>psychotropic pharmacy recommendations will be reviewed quarterly at the QA meeting and discuss any that were reductions andor denials. A review of the current residents that are on PRN psychotropicmedications will be reviewed.</p>				

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	<p>medication at 5:30 P.M.</p> <p>The nurse's notes dated 10/14/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the anti-anxiety medication at 8:00 A.M.</p> <p>The nurse's notes dated 10/15/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the anti-anxiety medication at 10:30 P.M.</p> <p>The nurse's notes dated 10/18/14 and 10/19/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the anti-anxiety medication at 11:00 P.M.</p> <p>A nurse's note dated 10/19/14 at 0030 (12:30 A.M.) indicated, "...received prn Klonopin for restless at 2300 (11:00 P.M. on 10/18/14). The note lacked any documentation non-pharmacologic interventions had been attempted.</p> <p>The nurse's notes dated 10/21/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the</p>			

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	<p>administration of the anti-anxiety medication at 6:20 P.M.</p> <p>The nurse's notes dated 10/22/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the anti-anxiety medication at 8:30 A.M.</p> <p>The nurse's notes dated 10/25/14 were reviewed and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the anti-anxiety medication at 10:00 A.M.</p> <p>The MAR, nurse's medication notes and/or the nurse's notes indicated Resident #53 received 10 doses of as needed Klonopin 1 mg from October 6, 2014 through October 25, 2014 and lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the prn anti-anxiety medication.</p> <p>During an interview on 10/29/14 at 3:00 P.M., the DON (Director of Nursing) indicated no documentation could be provided to support Resident #53 had refused medication on 10/23/14 at 8:00 A.M. and/or 10/27/14 at 6:55 A.M. The</p>			

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	<p>DON further indicated, at that time, no documentation could be provided to indicate non-pharmacologic interventions had been attempted prior to the administration of Klonopin on the identified dates. The DON then indicated, the prn Zyprexa should have been administered only if medications had been refused and non-pharmacologic interventions should have been attempted prior to the administration of Klonopin.</p> <p>The Policy and Procedure for "Usage of PRN Psychotropic Medications" provided by the SSD (Social Services Director) on 10/29/14 at 3:28 P.M. indicated, "...It is the policy of the facility to administer PRN psychotropic medications only after other interventions have been attempted and failed...Assess resident for physical needs...after all behavioral interventions have been attempted and have been unsuccessful in redirecting the behavior, assess the need for PRN..."</p> <p>2. Resident #10's clinical record was reviewed on 10/23/14 at. Resident #10 had been admitted to the facility on 5/18/07. His current October 2014 physician orders included but were not limited to, diagnoses of dementia and schizoffective disorder. Current psychotropic medications included Seroquel (antipsychotic medication) 100</p>						

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	<p>mg po (orally) every PM (evening) and Seroquel 200 mg po every PM (original order date 12/06/12). He also had an order for Seroquel 300 mg po twice a day (original order date 6/7/12). Ambien (hypnotic medication) 5 mg po at hs prn for insomnia (original order date 7/1/12). Celexa (antidepressant medication) 40 mg at hs for psychosis (original order date (2/4/14).</p> <p>On 10/19/14 at 9:42 A.M., during interview with the Social Service Director (SSD) she indicated Resident #10 had been seen by the psychologist at the facility in July and September 2014. She indicated documentation was lacking of a pharmacy recommendation in 2014 regarding a gradual dose reduction for the medications Celexia, Ambien, and Seroquel.</p> <p>On 10/29/14 at 10:40 A.M., the SSD provided the most recent pharmacy recommendation regarding psychotropic medications for Resident #10, which was for the medication Ambien. The pharmacy recommendation was dated 6/11/13 and indicated, "MAY WE HAVE A DX (DIAGNOSIS) FOR PRN (WHEN NEEDED) AMBIEN?"</p> <p>On 10/29/14 at 1:25 P.M., during interview with the Healthcare Facility</p>						

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	<p>Administrator (HFA), she indicated the psychologist who provided services for residents at the facility had requested that pharmacy provide recommendations for gradual dose reductions of psychotropic medications.</p> <p>3. Resident #34's clinical record was reviewed on 10/27/14 at 11:00 A.M. Resident #34 had been admitted to the facility on 7/23/09. Her current diagnoses list included but were not limited to, alcoholism, hallucinations, and depressive disorder. Her current 2014 October physician orders included a psychotropic medication, Risperdal (antipsychotic medication) 0.25 mg po daily (original order date 7/5/13). Her medications also included Cymbalta (antidepressant medication) 60 mg every day (original order date 7/5/13).</p> <p>On 10/29/14 at 8:21 A.M., during interview with the Social Service Director (SSD) she indicated there had not been a pharmacy recommendation for a gradual dose reduction of the medications Risperdal or Cymbalta in 2014.</p> <p>The SSD provided documentation on 10/29/14 at 10:40 A.M., of a pharmacy recommendation sheet dated 6/11/13 which included "... MAY WE</p>						

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F000431 SS=E	<p>DECREASE RISPERDAL TO QD?"</p> <p>The documentation indicated the physician had agreed to the recommendation.</p> <p>On 10/29/14 at 1:10 P.M., a facility policy entitled, "PSYCHOTROPIC MEDICATION DOSE REDUCTION POLICY AND PROCEDURE (undated) was received and reviewed. The policy included but was not limited to, "... 3. the Consultant Pharmacist will review all records of residents receiving psychotropic drugs on a quarterly basis and will recommend gradual dose reductions to the primary care physicians when appropriate..."</p> <p>The Director of Nursing (DON) on 10/29/14 at 2:04 P.M., indicated she was unable to provide pharmacy recommendations in 2014 for gradual dose reduction for Risperdal or Cymbalta.</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt</p>						

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	<p>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 disposed of in a timely manner and/or medications were properly stored, in that, 1 of 3 medication carts and 2 of 2 medication storage rooms had expired medications, and the facility failed to store oral medication separate from personal hygiene items. (Resident</p>	F000431	F431 Resident # 22, #15, E, #6, #34, #5 experiences no ill effects from alleged deficiency. All expired Medications were disposed of per policy and personal care items were removed from the medication cart. All residents have the potential to be affected by the alleged deficiency therefore thru alterations and in-services the	11/28/2014

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	<p>#22, Resident #15, Resident E, Resident #6, Resident #34, Resident #5)</p> <p>Findings Include:</p> <p>1. On 10/29/14 at 9:00 A.M., an observation of the facility medication storage rooms was completed with the Assistant Director of Nursing (ADON). During the observations, the following medications were observed in the refrigerators of the East and West hall:</p> <p>Two expired vials of Tubersol 5TU/0.1 ML (an injectable solution used to aid in the diagnosis of tuberculosis infection) with an expiration date of September 20, 2014 documented on the packaging.</p> <p>During an interview with the ADON at that time, she confirmed the Tubersol was expired and needed to be disposed of and reordered.</p> <p>2. On 10/29/14 at 9:40 A.M., the following items were observed in the drawers of medication cart #2 with QMA #5 on the West hall:</p> <p>Resident #22's medication drawer contained his prescription medications and 2 used shaving razors, a plastic razor holder with soap film noted on it, 2 razor blades and 2 unopened packages of 8</p>		<p>facility will assure Medications are stored appropriately and disposed of in a timely manner. All medication carts have been audited to assure medications are being stored per policy and not expired. Nurses have been in-serviced on facility procedure for monitoring of the expired medications, documentation of the dates that medications were opened and storage of personal items. Systemic changes are that nurses will now be required to label insulin, eye gtts and tubersol with "date opened" and "date to be discarded". Systemic changes made in that personal items are to be labeled and stored in a different locked location. DON/Designee will review 3 random resident medications to assure that these are labeled with the date opened and the appropriate discard date, along with assuring that no personal items are being stored in medication cart drawers. This will be done 5 times weekly for 1 month, then 3 times weekly for one month, then weekly for 6 months and Monthly x 3 with results forwarded to the QA committee for further suggestions/comments.</p>				

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	<p>razor blades.</p> <p>Resident #15's medication drawer contained her medication and a watch along with a one quart plastic ziplock baggie filled with jewelry.</p> <p>Resident E's medication drawer contained her prescription medications along with her finger nail clippers.</p> <p>During an interview on 10/30/14 at 11:30 A.M., the ADON indicated a resident's personal hygiene products and other personal items should not be stored in the medication carts along with a resident's prescription medications.</p> <p>3. On 10/29/14 at 11:40 A.M., during an observation with RN #6, the following items were observed in medication cart #3 located on the East hall: Resident #6 had one 10 ml multidose vial of Novolog insulin with an expiration date of 10/21/14 documented on the packaging.</p> <p>Resident #6 had one multidose vial of Levemir 100 u/ml insulin which had an expiration date of 10/28/14 documented on the packaging.</p> <p>Resident #34 had one 10 ml multidose vial of Lantus insulin which had the opening date documented on the packaging as 9/20/14.</p>						

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F000465 SS=D	<p>Resident #5 had one 5 ml multidose vial of Atropine1% (medication used post eye surgery or used for an inflammatory condition of the eye) with an expiration date of 9/20/14 documented on the packaging.</p> <p>An undated policy titled," MEDICATION STORAGE IN THE FACILITY", was provided by the ADON on 10/29/14 at 10:51 A.M. The policy included, "...P. Insulins and eye drops are to be dated upon opening and are to be used for 30 days at which time they will expire and need to be reordered..."</p> <p>During an interview on 10/29/14 at 1:26 P.M., the ADON confirmed the insulin and eye drop medications were expired and needed to be disposed of and reordered.</p> <p>3.1-25(n) 3.1-25(o) 3.1-25(r)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain the facility in a</p>	F000465	F465 All resident had the potential to be affected by the alleged deficiency and through	11/28/2014			

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	<p>sanitary and/or safe manner, in that, 2 of 7 windows in the library were found to be in disrepair.</p> <p>Findings include:</p> <p>1. On 10/28/14 at 9:00 A.M., a tour of the exterior of the facility was conducted with the maintenance supervisor. During the observation, 2 of the windows along the library were observed to be in disrepair. The coating along the base of the windows was missing and cracked leaving the inner wood exposed and found to be wet.</p> <p>2. On 10/28/14 at 9:00 A.M., the Maintenance Supervisor was interviewed. She indicated that they were aware of the windows being in disrepair and were in the process getting estimates to replace them.</p> <p>3. On 10/29/14 at 3:22 P.M., during an interview with the Administrator she indicated she was aware of the concern with the windows. She further indicated they were in the process of making improvements and the windows were on the list to be replaced.</p> <p>This Federal tag relates to Complaint IN00156660.</p>		<p>alterations and processes and in servicing the facility will ensure to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Systemic change is that both windows identified on the 2567 have been ordered and are being replaced. All windows in the facility have been inspected to assure no others are in disrepair. Maintenance Supervisor/Designee will complete window audits in 3 rooms to assure windows are not in disrepair. This will be done 5 times weekly for 1 month, then 3 times weekly for one month, then weekly x 6 months with results forwarded to the QA committee for further suggestions/comments.</p>				

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	3.1-19(f)				