

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15A014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/26/2012
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NAME OF PROVIDER OR SUPPLIER  VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00107975.</p> <p>Complaint IN00107975 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 20, 21, 22, 25 and 26, 2012</p> <p>Facility number: 000274 Provider number: 15A014 AIM number: 100271660</p> <p>Survey team : Linn Mackey RN TC Shelley Reed RN Julie Call RN Virginia Terveer RN Toni Maley BSW (6/25/12)</p> <p>Census Bed Type: NF: 88 Total: 88</p> <p>Census payor type: Medicaid: 88 Other: 0 Total: 88</p> <p>These deficiencies also reflect state</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Vernon Manor Children's Home desires this Plan of Correction to be considered the facility's Allegation of compliance. Compliance is effective on 07/13/2012</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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	findings cited in accordance with 410 IAC 16.2  Quality review 6/29/12 by Suzanne Williams, RN				

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F0160 SS=A	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on interview and record review, the facility failed to return personal funds to the appropriate agency after the resident's death for 1 of 3 records in a sample of 3 closed records reviewed for the conveyance of funds. (Resident #25).</p> <p>Findings include:</p> <p>During an interview with the Business Office Manager on 6/26/12 at 9:52 a.m., the Business Office Manager provided a list of residents who had died in the past three months. The Business Office Manager provided the statements of conveyance for the residents, including Resident #25.</p> <p>During record review on 6/26/12 at 10:30 a.m., the accounting statement of conveyance, dated from 5/26/12 to 6/1/12 for Resident #25, indicated a balance of \$707.19 has remained in</p>	F0160	<p>It is the policy of this facility to return personal funds to the appropriate agency after the resident's death within 30 days.</p> <p><u>1. What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> Business office manager was immediately re-educated on the Policy and Procedure for Resident Funds refunds on 06/21/2012.(EXHIBIT 1-1A) A check request was completed to refund the money to the appropriated agency. (EXHIBIT 2)</p> <p><u>2. How will the facility indentify other residents who could have been affected by the practice?</u> An audit was completed of all Discharged resident in the last six (6) months. No other resident was found to have been affected.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u> A new process was initiated.(EXHIBIT 3) Upon the death of a resident The Central Business Office will review the account and if a refund is do will cut a check to close the resident account. The check will be sent to the Executive Director for</p>	07/13/2012	

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	Resident #25's account since her death on 5/8/12 and has not been returned to the appropriate agency within 30 days of the resident's death.  3.1-6(h)		distribution. <u>4. How ill the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Up on the death of a resident the Executive Director will audit the resident's account in twenty (20) days to ensure proper refund has been made. Results of this audit will be brought to QA monthly x's 6 months. Further need for monitoring will be determined by QA Committee. <u>5. Date of compliance:</u> 07/13/2012		

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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>Based on observation, record review and interview, the facility failed to ensure safe water temperatures in 3 bathrooms on 1 of 6 halls (Timms hall). This deficient practice had the potential of affecting 20 residents of 88 residents in the facility.</p> <p>Findings included:</p> <p>During observations of residents' rooms on 6/20/12 and 6/21/12, water temperatures were hot to touch. Temperatures were taken in the following residents' rooms at that time. Temperatures were as follows:</p> <p>The bathroom shared by resident rooms 301 and 302 had water temperatures of 131.5 at the sink, and 128.5 at the shower. Four residents shared this bathroom.</p> <p>The bathroom shared by resident rooms 305 and 306 had water temperature of 124 at the sink, and 127 in the shower. Eight residents shared this bathroom.</p>	F0323	<p>F 323It is the policy of this facility to ensure that the residents' environment remains as free of accidents hazards as is possible.1. What corrective action will be done by the facility for those residents found to have been affected by this practice? No resident was affected by the practice.2. How will the facility indentify other residents who could have been affected by the practice? 20 residents who lived on this wing had the potential of being affected. 3. What measures will be put into place to ensure this practice does not recur?The facility immediately initiated taking hourly water temperatures and adjusting as needed. The contracted plumber was notified and repaired the mixing valve on 06/22/12 The Maintenance Director and Environmental Supervisor was re-educated on the water temperature Policy on 06/21/12. (EXHIBIT 4-4B)4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?Water temperatures will be monitored on all boiler systems weekly by</p>	07/13/2012

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	<p>The bathroom shared by resident rooms 307 and 308 had water temperatures at the sink of 134.8 and 129 in the shower. Eight residents shared this bathroom.</p> <p>Interview with the Administrator on 6/21/12 at 12:30 p.m., indicated there were no residents who were able to use their bathroom on their own, and there also had been no injuries from water temperatures.</p> <p>During a tour with the Maintenance Supervisor on 6/21/12 at 1:00 p.m., the gauge on the water heater that heats the 300 hall showed 110 degrees. Hot water temperatures were taken during this tour and were as follows: Room 301-302: temperature 128 Room 307-308: temperature 128 Room 305-306: temperature 128</p> <p>Review of a document titled "water temps" on 6/21/12 at 1:30 p.m. indicated fluctuations of temperatures between 86 to 130 degrees on the Timms hall, which affected the following rooms: Rooms 301-302 Rooms 303- 304 Rooms 305-306 Review of repair requisitions on</p>		<p>Environmental Supervisor/Designee on going. ED will be immediately notified of any temperature out of acceptable range. Executive Director/designee will review the temperature logs weekly x's 2 months, bi-weekly x's 1 months, than Monthly xs 2 months than randomly thereafter. Results of these audits will be taken to QA x's eight (8) months. Further need of monitoring will be determined by QA Committee. Water temperatures will continue to be taken on all boiler systems weekly on going. <u>Date of compliance:</u> 07/13/2012</p>				

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	<p>6/21/12 at 1:30 p.m. showed the facility adjusted the water temperatures and rechecked the temperatures.</p> <p>Interview with a contracted plumbing employee on 6/22/12 at 2:00 p.m. indicated there was a problem with a backflow valve that was causing fluctuations of temperatures and the problem was now fixed.</p> <p>Interview with the Maintenance Director on 6/26/12 at 2:00 p.m., indicated the valve would stick at times and then open. The valve was located where the hot and cold water combined to control temperatures of the water.</p> <p>Review of a policy titled Water Temperatures, received from the Administrator on 6/21/12 at 2:00 p.m. indicated water temperatures in resident rooms, bathrooms, common areas and tub/shower shall be set to temperatures of no more than 120 degrees.</p> <p>3.1-45(a)(1)</p>				

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F0332 SS=E	<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 a medication error rate of less than 5% as evidenced by 8 medication errors out of 55 opportunities with a medication error rate of 14.5%, affecting 7 of 24 residents observed during medication pass. (Residents #7, #8, #14, #39, #43, #60, #64)</p> <p>Finding include:</p> <p>1) During observation of medication administration on 06/22/12 at 2:24 P.M., LPN #2 gave Resident # 39 Calcium 600 mg (milligrams) + Vitamin D (decreases bone loss) 200 IU (International Unit), 1 tablet via (through) G-tube (feeding tube used for long term nutrition). The record review for Resident #39 on 6/22/12 at 4:30 P.M., indicated Physician Orders for Calcium 600 mg + Vitamin D 400 IU, give 1 tablet, 3 times per day via G-tube for osteoporosis.</p> <p>2) During observation of medication administration on 06/22/12 at 2:28</p>	F0332	<p>F 332It is the policy of this facility to ensure that the residents receive Medications as proscribed by their physician. <u>1. What corrective action will be done by the facility for those residents found to have been affected by this practice? Medication error forms were completed. (EXHIBIT 5) families and Doctor notified Ferrous Sulfate and Ranitidine. Nurse #1 was re-educated on Medication pass procedures. (EXHIBIT 6 -6A-6B). physicians orders were clarified.2. How will the facility identify other residents who could have been affected by the practice? An audit was completed for all residents receiving Calcium, Ferrous Sulfate and Ranitidine. 20 residents had the potential of being affected. If affected Medication error forms were completed, families and Doctor notified Ferrous Sulfate and Ranitidine. Physicians orders were clarified.3. What measures will be put into place to ensure this practice does not recur? Nursing staff re-educated on Medication pass procedures. (EXHIBIT 7-7A-7B) DON/Designee will review new orders, medication sheets and medication received</u></p>	07/13/2012	

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	<p>P.M., LPN #3 gave Resident # 8 Calcium 600 mg + Vitamin D 800 IU, 1 tablet via G-tube. The record review for Resident # 8 on 6/22/12/at 4:30 P.M., indicated Physician's Orders for Calcium 600 mg + Vitamin D 400 IU, give 1 tablet, 3 times per day via G-tube for osteoporosis.</p> <p>During an interview with LPN #3, on 06/22/12 at 2:28 P.M., LPN #3 indicated Calcium + Vitamin D is provided from the facility stock and not the pharmacy. During observation of the Calcium bottle, it was labeled with the Resident's name, room number and physician's name.</p> <p>3) During observation of medication administration on 06/22/12 at 2:41 P.M., LPN #3 gave Resident # 43 Calcium 600 mg + Vitamin D 800 IU, 1 tablet via G-tube. The record review for Resident # 43 on 6/22/12 at 4:30 P.M., indicated the Physician's Order was for Calcium 600 mg + Vitamin D 400 IU, give 1 tablet, 3 times per day via G-tube for osteoporosis.</p> <p>4) During observation of medication administration on 06/22/12 at 2:59 P.M., LPN #3 gave Resident # 14 Calcium 600 mg + Vitamin D 800 IU, 1 tablet, via G-tube. The record</p>		<p><u>for calcium to ensure proper dosage and proper administration time, ferrous sulfate and Ranitidine on days of work on going. New orders will be reviewed in daily stand up meeting on days of work on going. DON/Design will than observe Nurse #1 and one (1) nurse on each shift's med pass 1 x week x 4weeks, than bi weekly xs 2 months, monthly x's 2 months than randomly there after. (EXHIBIT 8 8A) 4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? DON/Designee will review new orders, medication sheets and medication received for calcium to ensure proper dosage and proper administration time, ferrous sulfate and Ranitidine on days of work and bring to daily stand up meeting on going. DON/Design will than observe Nurse #1and 1 additional nurse on each shift's med pass1 x week x 4,than bi-weekly xs 1 months, than monthly x 2, randomly there after. Results of this monitoring will be brought to QA monthly x 8 months. Further need for monitoring will be determine by QA Committee. <u>Date of compliance: 07/13/2012</u></u></p>				

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	<p>review for Resident # 14 on 6/22/12 at 4:40 P.M., indicated the Physician's Order was for Calcium 600 mg + Vitamin D 400 IU, give 1 tablet, 3 times per day via G-tube for osteoporosis.</p> <p>5) During observation of medication administration on 06/25/12 at 3:24 P.M., LPN #1 gave Resident # 60 Diazepam (for muscle spasms and seizures) 10 mg 1 tab via G-tube and Baclofen (muscle relaxant, muscle spasms) 10 mg, 3 tablets via G-tube were given. Erythromycin was not given at this time. The record review on 6/26/12 at 12:15 P.M. of Physician Orders during the reconciliation of medications given to Resident # 60 indicated the Erythromycin (used to treat gastrointestinal movement) 250 mg 1 tablet was not given at 3:00 P.M. as ordered by physician.</p> <p>6) During observation of medication administration on 06/25/12 at 3:36 P.M., LPN #3 gave Resident # 7 Calcium 600 mg + Vitamin D 800 IU, 1 tablet via G-tube. The record review for Resident #7 on 6/25/12 4:00 P.M., indicated the Physician's Order was for Calcium 600 mg + Vitamin D 400 IU, give 1 tablet, 3 times per day via G-tube for osteoporosis.</p>			

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	<p>An interview with LPN #3 on 6/25/12 at 3:45 P.M. indicated the Calcium 600 mg + Vitamin D is provided to residents from the facility stock, the medication bottle was to be labeled with the Resident's name, room number and Physician's name. LPN #3 indicated the dose of Vitamin D is 800 IU in the facility's stock of the Calcium 600 mg + Vitamin D.</p> <p>7) During observation of medication administration on 06/26/12 at 9:41 A.M., RN #4 gave Resident #64, Ferrous Sulfate (Iron used for anemia) 220 mg/5 ml Elixir, gave 6.9 ml via G-tube. The record review for Resident # 64 on 6/26/12 at 10:00 A.M., indicated the Physician's Order was for Ferrous Sulfate 220 mg/5 ml, give 6.9 ml (304 mg) via G-tube at 7 a.m. daily.</p> <p>According to WebMD.com, this medication is to be given on an empty stomach, 1 hour before or 2 hours after food. Avoid taking with antacids, dairy products with in 2 hours of taking Ferrous Sulfate.</p> <p>During observation of medication administration on 06/26/12 at 9:43 A.M., RN #4 gave Resident #64, Ranitidine (used to inhibit stomach</p>			

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	<p>acid production) 15 mg/ml, gave 5 ml (75 mg) via G-tube. The record review for Resident # 64 on 6/26/12 at 10:00 A.M., indicated the Physician's Order for Ranitidine 15 mg/ml, give 5 ml (75 mg) via G-tube at 7 a.m. daily.</p> <p>According to WebMD.com this medication decreases acid in the stomach and may interfere with absorption of drugs that require acid for adequate absorption such as Iron sulfates...</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F0431 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 2 of 3 medication storage rooms/areas were locked and failed</p>	F0431	F 431It is the policy of this facility to ensure that medication storage rooms/areas are locked and to ensure the narcotics/controlled medication counts are accurate.1.	07/13/2012			

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	<p>to ensure the narcotics/controlled medication counts were accurate for 4 residents' medications randomly observed in 2 of 5 medication carts.</p> <p>Findings include:</p> <p>1. During an observation on 6-22-2012 at 1:35 P.M., a treatment cabinet in the unstaffed nurse's station in the front hall was unlocked and contained betadine, dressing supplies, hand foam, alcohol free hand sanitizer and stomahesive paste.</p> <p>An interview with LPN #2 on 6-22-2012 at 1:51 P.M., indicated the cabinet lock was broken. LPN #2 removed the betadine, hand foam, alcohol free hand sanitizer and stomahesive, and moved the supplies to a locked cabinet.</p> <p>During an observation on 6-26-2012 at 11:20 A.M., the Medication room door in Hall 300 was left open without a nurse present in the nurse's station.</p> <p>During an interview with the DON on 6-26-2012 just after 11:20 A.M., the DON was informed of the Medication Room door being left open in Hall 300 without a nurse present. The DON went to shut the Medication Room</p>		<p>What corrective action will be done by the facility for those residents found to have been affected by this practice? No resident was affected by this practice.2. How will the facility indentify other residents who could have been affected by the practice? No other residents were affected by this practice.3. What measures will be put into place to ensure this practice does not recur? Maintenance Director immediately repaired the broken cabinet lock on 6/22/12. Nursing staff were re-educated on completing maintenance request forms and to immediately move medications to secured area when locks are broken. Nursing staff was re-educated on keeping medication storage areas doors closed and locked on 6/25/12 (EXHIBIT 9-9A). On 6/26/12 an audit was completed of all medication carts and storage to assure controlled substances had a controlled substance log/count sheet. No others were found. Nurses were re-educated on Controlled Substance logs/count sheets.(EXHIBIT 10-10A) 4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> DON/Designee will audit medication carts to assure controlled substance have a count sheet weekly x 1 month, bi-weekly xs 2 months, then monthly x 2 months.(EXHIBIT 11)</p>				

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	<p>door in Hall 300 and was going to inform the nurse.</p> <p>On 6-25-2012 at 5:20 P.M., a policy titled, "Medication Administration" was provided by the Administrator and indicated "....medication carts are to be locked when out of the sight of the licensed nurse...."</p> <p>2. On 6-25-2012 at 10:35 A.M., LPN #1 was observed reconciling the narcotic/controlled medication count for Resident #83 in one of the medication carts. The paperwork indicated 6 Diastat (anti-seizure medication) 2.2 mg pedi system suppository doses should be present when only 4 doses of the Diastat 2.2 mg pedi system suppository doses were in the locked narcotic/controlled medication compartment of the medication cart.</p> <p>3. During an observation on 6-25-2012 at 10:56 A.M. with LPN #1, the controlled medications for 3 residents (#55, #60, #74) were not being accounted for on the facility "Controlled Substance or Controlled Drug Record." The medications included 1 kit containing 1 dose of Diazepam (seizure control) 10 mg (milligram) rectal for 1 resident, 3 doses of Diastat 2.5 mg rectally as</p>		<p>and randomly thereafter. All managers will monitor locked cabinets and medication room doors on assigned daily rounds on going. Results of audits will be brought to QA x 8 months. Further need for monitoring will be determined by QA Committee. <u>Date of compliance:</u> <u>07/13/2012</u></p>				

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	<p>needed for seizure activity for another resident and 4 doses (2 kits) of the Diazepam 10 mg rectal for a seizure lasting 5 minutes as needed for the third resident.</p> <p>An interview with LPN #1 on 6-25-2012 after the 10:56 A.M. review of the controlled medication reconciliation, indicated there was one extra Controlled Drug Record form created in error for the Diastat. LPN #1 indicated there should have been a Controlled Drug Record for each of the 3 resident's controlled medications for reconciliation.</p> <p>On 6-25-2012 at 3:50 P.M., a policy, Controlled Medications/Narcotic Management was provided by the Business Office Manager and indicated "...8. Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together, document the count and report any discrepancies to the Director of Nursing Services...."</p> <p>During an interview with the DON on 6-26-2012 at 8:30 A.M., the DON was notified of the Controlled Medication findings and the DON indicated she would investigate the situation. No</p>				

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	<p>additional documentation was provided by the DON.</p> <p>3.1-25(m) 3.1-25(n)</p>			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to follow</p>	F0441	F 441It is the policy of this facility to Maintain an Infection Control	07/13/2012			

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	<p>infection control procedures for 1 of 3 observed residents' wound care/treatments (Resident #87), the handling of medications for 1 of 25 residents (#71) during medication pass and 1 random resident's (#85) medication count during the narcotic/controlled medication reconciliation.</p> <p>Findings include:</p> <p>1. On 6-25-2012 at 1:03 P.M., LPN #13 was observed during a dressing change for Resident #87, to remove and donn gloves 4 times during the procedure without performing hand hygiene or hand washing after removal of the gloves and prior to donning a new pair of gloves.</p> <p>A policy for Clean Dressing Application was provided on 6-25-2012 by the Business Office Manager and indicated ".....remove and discard gloves....perform hand hygiene and apply new gloves...."</p> <p>A policy for Handwashing and Use of Gloves was provided on 6-25-2012 by the Business Office Manager and indicated "....hand hygiene is performed after removing gloves."</p> <p>2. On 6-25-2012 at 10:40 A.M., LPN</p>		<p>Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.1. What corrective action will be done by the facility for those residents found to have been affected by this practice? Nurse #13 was re-educated regarding the Policy/procedure for dressing change and Hand washing. ((EXHIBIT 12-12A-12B-12C) Medication for resident #85 were discarded per policy and medication replaced. Nurse # 1 was re-educated on Medication Administration Policy. (EXHIBIT 13-13A-13B)2. How will the facility indentify other residents who could have been affected by the practice? No other resident on 100 hall receives dressing changes. No other resident on 200 hall has multiple dose packaging for controlled substances . All resident who receive medications on the 200 hall by tube were at risk by this practice in Medication Administration.3. What measures will be put into place to ensure this practice does not recur? Nursing staff was re-educated on the Policy/procedure for dressing change, Hand washing, and Medication Administration (EXHIBIT 14-14A-14B-14C14D-14E). 4. <u>How will the corrective action be monitored to ensure the deficient</u></p>		

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	<p>#1 was observed to dump 8 pills from a pill bottle for Resident #85 containing Diazepam (for muscle spasms and seizures) 5 mg (milligram) tabs into her hand to count them and then return the pills to the bottle and to the locked narcotic drawer within the medication cart.</p> <p>3. On 6-25-2012 at 3:31 P.M., LPN #1 was observed during med pass to place a Baclofen (muscle relaxant to decrease muscle spasms) tab in her hand before placing the pill in the med cup, crushing it and then giving through the G-tube (feeding tube used for long term nutrition) to the Resident #71.</p> <p>On 6-25-2012 at 5:20 P.M., a policy, Medication Administration was provided by the Administrator and indicated "....do not touch medication when opening a bottle or unit dose package...."</p> <p>3.1-18(b)(2) 3.1-18(l)</p>		<p><u>practice does not recur and what QA will be put into place?</u> DON/Designee will observe 1 dressing change and 1 medication pass per week on each shift x 4 weeks then bi-weekly x 1month, x monthly x 2 months, than randomly thereafter (EXHIBIT 15-15A). Results of observation will be brought to QA monthly x 8 months. Further need for monitoring will be determined by the QA Committee. <u>Date of compliance: 07/13/2012</u></p>		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review, observation and interview, the facility failed to ensure complete documentation of physician ordered nutritional supplement for 1 of 3 residents reviewed for nutrition of 12 residents who met the criteria for nutrition and failed to obtain physicians orders for the restrictive equipment used for 1 resident of 28 observed with restrictive equipment. (Resident #43 and Resident #87)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #43 was reviewed on 6/26/12 at 10:00 A.M.</p> <p>Diagnoses included, but were not limited to, profound intellectual</p>	F0514	<p>F514It is the policy of this facility to Maintain Clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented and readily accessible and systematically organized.1. What corrective action will be done by the facility for those residents found to have been affected by this practice? Ensure plus was added to the treatment record for resident # 43.(EXHIBIT 16) A physicians order was obtained for Resident #87 for his adaptive equipment including the electric wheelchair with waist belt, arm splints foot straps and bolsters. (EXHIBIT 17)2. How will the facility indentify other residents who could have been affected by the practice? A medical records audit was completed for residents with adaptive equipment and Residents receiving supplements.</p>	07/13/2012			

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	<p>disabilities, congenital microcephalus, convulsions, quadriplegic cerebral palsy, aphasia, and constipation.</p> <p>The Physician Order on 4/26/12 for Dietary Recommendations indicated, "1) DC (discontinue) fortified cereal at breakfast. 2) Start double portions dessert at lunch and dinner. 3) Change time of Ensure Plus to evening meal. 4) Weekly weights X 4 Weeks...."</p> <p>Interview on 6/26/12 at 11:19 a.m. with CNA #9 indicated when a resident receives Ensure, the CNA is to record it on the meal ticket and then the nurse records it in resident's record.</p> <p>During an interview on 6/26/12 at 11:30 a.m., LPN # 11 indicated the Ensure should be recorded in the food consumption book.</p> <p>During an interview on 6/26/12 at 1:30 p.m., RN #10 indicated the Ensure Plus was not charted anywhere in the clinical record for Resident #43, since it was ordered on 4/26/12. RN # 10 indicated the Ensure Plus should have been recorded on the Food Consumption Sheet.</p>		<p>No other resident was found to be affected.3. What measures will be put into place to ensure this practice does not recur? Nursing staff was re-educated on the Policy/procedure for documentation of Supplements and orders for adaptive equipment.(EXHIBIT 18) 4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> DON/Designee will review supplement and restrictive equipment documentation weekly x 4 weeks than Bi-weekly x 2 months, than monthly x 2 and randomly thereafter. (EXHIBIT 19) Results of audit will be brought to QA monthly x 8 months. Further need for monitoring will be determined by the QA Committee.<u>Date of compliance: 07/13/2012</u></p>				

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	<p>Interview with the Administrator on 6/26/12 at 2:10 p.m., indicated the facility could not provide documentation of consumption of Ensure Plus as ordered by Physician on 04/26/12</p> <p>2. On 6-22-12 at 10:55 A.M., record review for Resident #87 indicated the following:</p> <p>A Safety Device/Restrictive Assessment was completed for the Minimum Data Set assessment on 5-15-2012 and indicated Resident #87 had a wheelchair, waist belt, arm splints/braces, foot straps and bolsters.</p> <p>A MDS assessment completed on 5-16-2012, indicated in a (CAA) Care Area Assessment review report, Resident #87 used an electric wheelchair, mechanical lifts for transfers and use of bolsters while in bed.</p> <p>No physician orders were included in the medical record for the adaptive restrictive equipment including the electric wheelchair with a waist belt, arm splints/braces, foot straps and bolsters.</p> <p>An interview on 6-22-2012 at 11:00 A.M. with LPN #2, indicated Resident</p>				

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	<p>#87's physician orders did not include orders for the adaptive and restrictive equipment. LPN #2 indicated she would obtain an order for a PT (Physical Therapy)/OT (Occupational Therapy) evaluation for the equipment and restrictive device orders and needs.</p> <p>On 6-25-2012 at 5:35 P.M., Resident #87 was observed in bed with bolsters on both sides of the bed providing support. The electric wheel chair was in the room with a waist belt attached to the chair and foot straps attached to the bilateral foot rests. The arm brace was laying on the bedside table.</p> <p>On 6-26-12 at 11:20 A.M., the Administrator provided the Restraint Use policy that indicated "...restraints are applied only upon proper physician's order stating type of restraint..."</p> <p>3.1-50(a)(1)</p>				