

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155751	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
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NAME OF PROVIDER OR SUPPLIER  MEADOW LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 24, 25, 26, 27, 30, &amp; October 1, &amp; 2, 2013</p> <p>Facility number: 004831 Provider number: 155751 AIM number: 200809750</p> <p>Survey team: Cheryl Mabry, RN-TC (September 24, 26, 27, 30, &amp; October 1 &amp; 2, 2013) Melissa Gillis, RN Susan Worsham, RN (September 25, &amp; October 1, &amp; 2, 2013)</p> <p>Census bed type: SNF: 18 SNF/NF: 99 Residential: 50 Total: 167</p> <p>Census payor type: Medicare: 24 Medicaid: 70 Other: 73 Total: 167</p> <p>Residential sample: 7</p>	F000000	<p>We request this document serve as an allegation of compliance regarding this annual survey. This provider respectfully submits the corrective action identified in this document be considered an allegation of compliance and a paper/ desk review by representatives of the division be conducted.</p>	

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

TITLE

(X6) DATE

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 10, 2013; by Kimberly Perigo, RN.</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on record review and observation, the facility failed to ensure proper handwashing techniques were used by staff while serving food in the dining room, in that CNA #1 was observed not to her wash hands, as indicated by facility policy. This deficient practice had the potential to affect 13 out of 20 residents being served in the unit 6 dining room.</p> <p>Findings include:  On 9/25/2013 at 1:16 p.m., Staff Development Supervisor provided "Hand Hygiene" policy dated 03/2012, and indicated the policy was the one currently used by the facility. Review of the policy indicated, "Hand Hygiene... Procedure Steps...6. Use friction for at least 20 seconds... Note: 5 Moment of required hand hygiene: Before patient, before an aseptic task, after body fluid exposure</p>	F000371	<p>F-371It is the intention of Meadow Lakes Mooresville to procure, store, prepare and serve food under sanitary conditions. What corrective action will be accomplished for those residents to have been affected by this deficient practice: Staff are washing hands per fafacility policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Each resident on the 600 hall had the potential to be affected by this practice on the date of the citation. Education to be provided to the staff on proper hand hygiene along with the policy on passing meal trays and drinks by the Clinical Education Coordinator or designee by 11/05/2013. Skills validation for nursing staff conducted to ensure compliance by the Clinical Education Coordinator or designee by 11/05/2013. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Education provided to nursing</p>	11/05/2013			

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	<p>risk, after patient contact, after contact with patient surroundings."</p> <p>On 9/25/2013 at 1:16 p.m., the Staff Development Supervisor provided the "Standard Precaution Usage Guidelines" dated 10/2011, and indicated the policy was the one currently used by the facility. Review of the policy indicated, "Standard Precaution Usage Guidelines...Hand washing or Alcohol based hand rubs (ABHR). Before and after direct resident contact, before and after assisting a resident with meals, before and after assisting a resident with personal care..."</p> <p>Observation on 9/22/2013 at 12:100 p.m., of Unit 6 dining room, indicated CNA #1 served beverages to five residents before she washed her hands. CNA #1 was observed to wash her hands for 10 seconds. CNA #1 then served beverages to four more residents. Food trays arrived and CNA #1 was observed to serve trays to four residents and then washed her hands again for 10 seconds.</p> <p>3.1-21(i)(3)</p>		<p>to ensure proper hand washing and meal service, by the Clinical Education Coordinator or designee on or before 11/05/2013. Meal monitors are in place for each meal to ensure policies cited are corrected. How the corrective action will be monitored to ensure the deficient practice does not recur, IE what Quality Assurance Program will be put into place: Meal monitors are in place to ensure proper service and hand hygiene. The meal monitors will complete an audit of the cited practice to ensure compliance, including handwashing for the appropriate time required and proper service of meals and drinks. To ensure compliance, the Director of Nursing Services or designee is responsible for completing the continuous quality improvement tool weekly for four weeks, then two times per month for two months, then monthly for four months then quarterly to encompass all meals until continued compliance is maintained for two consecutive quarters. The results of the audit will be reviewed in the continuous quality improvement committee, overseen by the Executive Director or designee. The assigned threshold of 95% will be the standard of achievement of the goal. If the 85% threshold is not achieved, an action plan will be developed to ensure compliance.</p>		

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals</p>	F000431	F-431It is the intention of Meadow Lakes Mooresville to label all medications in accordance with currently accepted professional principles. What corrective action	11/05/2013	

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	<p>used in the facility had a documented date opened on multi dose insulin bottles, antacids, medicated mouthwashes, and had resident name on inhaler, as indicated by facility policy for 4 of 6 medication carts and 1 of 2 medication storage rooms.</p> <p>Findings include:</p> <p>Observation of the medication store room on 9/25/13 at 11:30 a.m., with LPN #3, indicated Resident #78's bottles of Mary's Magic Mouthwash, 2 of 3 bottles were opened with no documented open date. Interview with LPN #3 indicated she thought resident was not taking the Mouthwash anymore, but after checking current physician orders, discovered Resident #78 was still on the medication.</p> <p>Observation of 600 hall medication cart on 10/01/13 at 11:00 a.m., indicated Resident #73's eye drops did not have a documented open date on the bottle.</p> <p>Observation the medication cart on Memory care unit on 10/1/13 at 11:50 a.m., indicated 10 of 10 insulin bottles lacked a documented open date on them. Interview with LPN #4, at the</p>		<p>will be accomplished for those residents to have been affected by this deficient practice: The medications for the residents listed in the survey have an open date added to their bottles and vials. Resident 175 has their name on the advair. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Every resident with a bottle, vial or inhalant had the potential to be affected by this practice. Education was provided to the licensed nursing staff by the Clinical Education Coordinator or designee and will be completed on or before 11/05/2013. The education will include dating any bottle when it is opened, on the actual bottle. This will include insulin, mouthwash, inhalers, antacids, all others, and and labeling dispenser with the resident name. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Education provided by the Clinical Education Coordinator to be provided to the licensed nursing staff on or before 11/05/2013 on the proper labeling of medications when opened, per policy. An audit of all medication carts and medication storage rooms, by the Director of Nursing Services or designee to ensure all medications have</p>		

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	<p>time of the observation, indicated she was not aware the insulin bottle itself needed to be dated. Resident #81's Flonase was not dated with date opened. Resident #175's Advair (identified by LPN #4) had no name on the medication dispenser, nor a documented opened date.</p> <p>Observation of the 200 hall front medication cart on 10/1/13 at 12:10 p.m., indicated Residents' #61 and #206, had no documented date opened on the Milk of Magnesium bottles. Resident #83's Mylanta bottle had no documented open date. Resident #59's Colace had no documented open date. Resident #138's Lantus insulin had no documented open date. Resident #61's Humalog insulin had no documented open date.</p> <p>Observation of the 200 hall back medication cart on 10/1/13 at 12:30 p.m., indicated Resident #112's liquid tears and liquid potassium had no documented open date. Resident #70's Humalog insulin and Lantus insulin had no documented open date.</p> <p>Observation of the 100 hall front cart on 10/1/13 at 1:00 p.m., indicated Residents' #114, #70, #55, and #96</p>		<p>proper labeling will be complete by 11/05/2013. How the corrective action will be monitored to ensure the deficient practice does not recur, IE what Quality Assurance Program will be put into place: To ensure compliance, the Director of Nursing Services or designee is responsible for completion of the medication storage continuous quality improvement audit tool weekly for 4 weeks, then every other week for two months, then monthly for four months and then quarterly to encompass all medication carts and storage rooms until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the continuous quality improvement committee overseen by the Executive Director or designee. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</p>		

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	<p>had no documented open date on Mylanta. Resident # 158's Milk of Magnesia had no documented open date. Resident #40's Colace liquid had no documented open date. Resident #174's guanfacine liquid had no documented open date. Resident #166's NovoLog insulin had no documented open date.</p> <p>Interviews on 10/1/13; with LPN #1 at 11:00 a.m., LPN #2 at 12:00 noon, LPN #3 at 11:30 a.m., and LPN #4 at 11:50 a.m., indicated insulin medication expires 30 days after opening.</p> <p>Interview with the DON on 10/01/13 at 2:00 p.m., indicated there was no facility policy regarding dating a medication bottle after opening.</p> <p>Copy of policy received from the Staff Development Coordinator on 09/25/13 at 1:15 p.m., titled Labeling of Medication, with no written date, did not indicate when medications expired. Multi-dose insulins, Pneumonia, PDA, and Multi-dose vials expired 30 days after opening.</p> <p>Interview with the DON on 10/1/13 at 2:00 p.m., indicated they did not have a policy regarding dating medication when first opened. She indicated</p>			

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	<p>they only had the policy received from pharmacy that she had already provided.</p> <p>3.1-25(j) 3.1-25(k)(1)</p>				