

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2013
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NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00127408.</p> <p>Complaint #IN00127408 - Substantiated. Federal/state deficiencies related to the allegations are cited at F204.</p> <p>Survey dates: April 15, 16, 17, 18, and 19, 2013.</p> <p>Facility number: 000359 Provider number: 155566 AIM number: 100274920</p> <p>Survey team: Diane Nilson, RN, TC Carol Miller, RN Tim Long, RN Rick Blain, RN Sue Brooker, RD, April 19, 2013 only</p> <p>Census bed type: SNF/NF: 65</p>	F000000	<p>This plan of correction is to serve as Warsaw Meadow's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Warsaw Meadows or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</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>Total: 65</p> <p>Census payor type:</p> <p>Medicare: 15</p> <p>Medicaid: 43</p> <p>Other: 7</p> <p>Total: 65</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 23, 2013 by Randy Fry RN.</p>			

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F000204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>Based on record review and interview, the facility failed to notify a resident's family and involve them in the decision making progress prior to a resident being discharged from the facility. The facility also failed to ensure possessions belonging to the resident were not left behind. This affected 1 Resident B, in a sample of 3 residents reviewed for discharge.</p> <p>Findings include:</p> <p>The closed record for Resident B was reviewed, at 10:22 a.m., on 4/17/13, and indicated the resident was admitted to the facility on 1/11/13, with diagnoses including, but not limited to: Dementia with behavior disturbances, Alzheimer's type dementia, Alcohol dementia, and mood disorder secondary to closed head injury.</p> <p>Review of a psychiatric evaluation, from a inpatient behavioral unit, dated 2/16/13, indicated the resident was admitted from a local nursing facility on 2/15/13, for stabilization and</p>	F000204	<p>F204 483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHARGE It is the policy of Warsaw Meadows to ensure a safe and orderly transfer or discharge from the facility.</p> <p>I. Resident B was appropriately discharged due to the fact that he posed a risk to the safety of the other residents in the facility. The belongings of the resident have been located and have been mailed to the resident.</p> <p>II. This deficient practice has the potential to affect any resident being transferred or discharged from the facility.</p> <p>III. All transfer and discharge packets have been removed from the units and updated to ensure that all appropriate documents are present. Including, but not limited to: proof that the facility provided notice and an explanation for discharge, the explanation of the right to appeal the transfer or discharge, a bed hold policy, the name, address, phone number of the ombudsman. Also, if appropriate, the</p>	05/08/2013	

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	<p>safety, for being belligerent and striking out at staff and a peer. A transfer form, dated 3/7/13, indicated the resident was discharged from the behavior unit at the hospital back to the skilled nursing facility.</p> <p>A physician's order, dated 3/14/13, indicated the resident was sent to the emergency room for evaluation and treatment due to physical abuse of another resident.</p> <p>A nursing note, dated 3/14/13 at 2:50 p.m., indicated the resident was observed pushing a female resident just outside his door as he was passing through. He stated to staff, "I'm sorry I didn't mean to push her that hard. "</p> <p>Review of a Social Service progress note, dated 3/18/13, indicated someone from the psychiatric center spoke to the former Administrator on the phone, who informed them the resident could not return to the facility. The note indicated the representative from the psychiatric center indicated the Indiana State Department of Health (ISDH) would be contacted.</p> <p>Further social service progress notes on 3/18/13, indicated the resident's daughter phoned wanting to know why the resident was not allowed</p>		<p>number and address of the agency responsible for advocating for the developmentally disabled or mentally ill individual. All efforts will be made to provide at least 30 days notice prior to transfer or discharge unless one of the following situations exist: endangerment to the health or safety of others, when the resident's health has improved enough to allow a more immediate transfer or discharge, when a resident's urgent medical needs cannot be met in the facility or when the resident has not been in the facility for 30 days. The family is to be notified immediately of a transfer or discharge and be involved in the care planning process if the situation allows. All staff involved in discharges or transfers will be in serviced on appropriate documentation and procedures required for transfers and discharges on 05/08/2013.</p> <p>IV. Medical records will audit all transfers and discharges within 72 hours for appropriate documentation and signature of inventory sheet. The audit results will be reviewed monthly in QA until compliance is met at 100% for one full quarter.</p>		

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	<p>back in the facility. The daughter was told the decision was made at the corporate level for the protection of the other residents. The progress note indicated the decision not to have the resident return was just decided that day, and the daughter questioned why she had to find this out from the psychiatric center.</p> <p>Review of a Social Service progress note, dated 3/22/13, indicated the resident's family contacted the facility and informed them they would be in later that day to pick up the resident's belongings.</p> <p>Review of the inventory of personal effects document, dated 1/11/13, indicated the personal effects of the resident were signed in on 1/11/13, but there were no signatures upon discharge.</p> <p>There was also no notice of transfer or discharge with appeal rights in the closed record.</p> <p>The Social Service Director was interviewed, at 1:40 p.m., on 4/17/13. She indicated the resident was admitted to the facility on 1/11/13, and the facility was made aware of the resident's history and that the resident was aggressive toward family</p>						

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	<p>and others, had a history of alcohol abuse, and had a diagnosis of dementia. She indicated he had been admitted to a psychiatric facility on 2/15/13 for increased behaviors and returned to the nursing facility on 3/7/13. She indicated he was only back one week, and knocked another resident down and she hit her head. He opened the door to his room, and the other resident was walking past. She indicated Resident B pushed her, and she fell and hit her head. She indicated the resident was sent to the emergency room at the local hospital, and from there admitted to a psychiatric unit for evaluation. The Social worker indicated the former Administrator determined the resident could not come back to the facility after his stay at the psychiatric unit, and normally a 30 day notice would be issued when a resident was not allowed to return to the facility, but the former Administrator indicated he was concerned with the safety of other residents. The Social worker indicated a family member had come to the facility on 3/22/13 to pick up the resident's belongings, and indicated the resident was still at the psychiatric facility but they were looking for other facilities for placement. She indicated the resident's daughter</p>						

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	<p>had phoned on 4/16/13 about a missing razor and the social worker had looked and found the razor.</p> <p>The Social worker indicated usually 30 day notices were discussed by the Interdisciplinary Team (IDT) before the notice was issued. She indicated Resident B's notice was never issued because the IDT had not discussed a 30 day notice. She indicated she had discussed alternative placement with the resident's daughter, but had never issued a notice. She indicated the former Administrator and Corporate had decided not to take the resident back, so a notice was never issued.</p> <p>The policy for Discharging the Resident was provided by the Director of Nursing Services at 9:30 a.m., on 4/19/13.</p> <p>The policy was reviewed at 10:10 a.m., on 4/19/13, and revealed the following:</p> <ul style="list-style-type: none"> The resident should be consulted about the discharge; Discharges could be frightening to the resident. Approach the discharge in a positive manner; Reassure the resident that all his or her personal effects would be taken to his or her place of residence; Be careful in packing the resident's 						

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	<p>personal effects. Review the personal effects inventory with the resident or responsible party and have them sign off that they have received all personal effects.</p> <p>The DNS was interviewed at 1:06 pm on 4/19/13 and indicated when a resident is discharged from the facility, a resident discharge form , medication and treatment form, bed-hold/readmission policy, and notice of transfer and discharge form is filled out and a copy sent with the resident.</p> <p>This Federal tag relates to Complaint #IN00127408.</p> <p>3.1-12(a)(21)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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, record review, and interview, the facility failed to ensure physician's orders were followed for 1 of 10 residents reviewed for Unnecessary medications, Resident # 90, and for 1 of 40 residents (#65) reviewed for physician's orders.</p> <p>Findings include:</p> <p>1. The record for Resident #90 was reviewed at 8:39 a.m., on 4/18/13. Diagnoses included, but not limited to: Huntington's Chorea, subdural hematoma, dementia, depression, anxiety with behavioral disturbance, and mood disorder.</p> <p>A physician's order, dated 4/5/13, and signed by the physician on 4/10/13, indicated a new order for Vitamin D3, 5,000 units, by mouth, daily.</p> <p>Review of the Medication Administration Record (MAR) for</p>	F000282	<p>F282 483.20(k) (3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN It is the intent of Warsaw Meadows to ensure that physician's orders are followed in accordance with each resident's plan of care. I. Resident # 90 received a lower dose than ordered of Vitamin D for 10 days. The physician was called and the order was immediately clarified. II. All residents could potentially be affected by this deficient practice. III. Upon discussion with the Medical Director, the root cause of this deficiency was noted to be the practice of the lab faxing lab results to the facility and to the physician's office. This practice has been systemically changed so that the facility receives the lab results and then calls pertinent results to the physician's office directly. No further orders will be written on a lab and faxed to the facility. All orders will be written on Physician Order Forms. As for the side rail orders, every rail in the facility was audited and cross-referenced with the</p>	05/08/2013

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	<p>April, 2013, indicated this medication had been given on a daily basis.</p> <p>Review of a Vitamin D lab result, dated as ordered on 4/3/13, and printed on 4/5/13, indicated the vitamin D level was low. A physician's order, signed by the same physician as the order on 4/5/13, but dated as signed on 4/8/13, indicated begin Vitamin D3, 50,000 units, by mouth, every week.</p> <p>LPN #9 was interviewed, at 9:52 a.m., on 4/18/13. She indicated if she gets a lab result, she would copy the result and give it to the Director of Nursing Services (DNS), or the Assistant DNS so they could contact the physician. She indicated if the lab sent results to the physician's office and the physician wrote a new order, then faxed the lab and order back to the facility, then the nurse receiving the order was supposed to check the new order, and clarify it with the physician if needed.</p> <p>The DNS was interviewed at 9:54 a.m., on 4/18/13, and indicated she would contact the physician and clarify the dosage, since there were 2 different dosages ordered.</p> <p>The DNS was interviewed, at 2:43 p.m., on 4/18/13, and indicated the</p>		<p>physician order on 04/29/2013. An IDT review was completed and all appropriate orders obtained. Nursing staff is to be in serviced on 05/08/2013 regarding the side rail guidelines and physician orders. IV. All care plans will be audited during the week of the scheduled care plans to assure side rail screens and physician orders are properly completed. It has been added to the housekeeping checklist for discharge to have the current bed rails removed from the bed to insure that the next resident admitted to the room has the appropriate device in place. The Director of Nursing/Designee will monitor all residents with a side rail order monthly for compliance for one quarterly then quarterly thereafter until compliance is 100% for two full quarters.</p>				

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	<p>physician was contacted and ordered Vitamin D3, 50,000 units weekly. She indicated normally the nurses checked labs that came back and if new orders needed to be clarified, they would contact the physician. The MAR indicated 10 incorrect doses of vitamin D had been given to the resident after the physician's order was clarified.</p> <p>The policy for Medication Orders was provided by the Director of Nursing Services, at 9:38 a.m., on 4/19/13. The policy was reviewed at 9:50 a.m., on 4/19/13, and indicated the following: "Medications are administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. Verbal orders are received only by licensed nurses or pharmacists and confirmed in writing by the prescriber." The policy further indicated the following: The prescriber would be contacted by the facility to verify or clarify an order, i.e, if the directions were confusing; Each medication would be documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order would be recorded</p>				

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	<p>on the physician's order sheet or the telephone order sheet if it was a verbal order, and on the Medication Administration Record.</p> <p>If an order was faxed from the physician's office, the nurse on duty at the time the order was received would note the order and enter it on the physician's order sheet.</p> <p>2. During observation of resident #65's bedroom on 4/15/13 at 1:35 P.M., it was noted the resident's bed had two half siderails. The right side bed side rail was noted to have three gaps of 8 & 1/4" x 8 & 1/4" on the top, bottom and middle of the siderail. The Administrator and Director of Nursing (DN) were notified of the the bed siderail and the siderail was removed.</p> <p>Review of the resident's physician's orders, dated 3/28/13, indicated "side rails x's 2 quarter length.</p> <p>An interview with the administrator on 4/19/13 at 2:30 P.M. indicated the side rail removed from resident #65's bed was 1/2 length. The adminitrator indicated the physician's order indicated 1/4 length bed side rails.</p> <p>3.1-35(g)(2)</p>						

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F000323 SS=D	<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, interview and record review the facility failed to ensure 1 of 40 residents (#65) reviewed for safe bed side rails, was free from gaps too wide to ensure safety.</p> <p>Findings include:</p> <p>During observation of resident #65's bedroom on 4/15/13 at 1:35 P.M., it was noted the resident's bed had two half siderails. The right side bed side rail was noted to have three gaps of 8 & 1/4" x 8 & 1/4" on the top, bottom and middle of the siderail. The Administrator and Director of Nursing (DN) were notified of the the bed siderail and the siderail was removed.</p> <p>Review of the resident's physician's orders, dated 3/28/13, indicated "side rails x's 2 quarter length.</p> <p>Review of the resident's most recent quarterly nursing assessment on</p>	F000323	<p>It is the intent of Warsaw Meadows to ensure that the residents' environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>I. The side rail on resident #65's bed was immediately removed from the bed and removed from the facility. Resident #65 has suffered no injury due to the side rail.</p> <p>II. All residents and future residents could be affected by this deficient practice.</p> <p>III. Every rail in the facility was audited and cross-referenced with the physician order on 04/29/2013. An IDT review was completed and all appropriate orders obtained. Existing side rails on empty beds were removed. The nursing staff and housekeeping staff will be in serviced on 05/08/2013 regarding the side rail regulations and compliance issues.</p> <p>IV. All care plans will be audited during the week of the scheduled care plans to assure</p>	05/08/2013	

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	<p>1/28/13 indicated in the bed rail safety assessment section: quarter length bed rails are used for safety due to a history of falls. The bed rail assessemnt indicated the resident was: non-ambulatory; needed assistance with bed mobility; has difficulty moving to a sitting position on side of bed; had difficulty with balance or poor trunk control. The bed rail safety assessment also indicated the resident did not have a history of falls.</p> <p>Review of the resident's quarterly nursing assessment prior to the 1/28/13 assessment, dated 10/30/12, indicated under the bed rail safety assessment, bed rails were not indicated.</p> <p>The most recent fall risk assessment from 1/28/13 indicated the resident did not have a history of falls in the past 3 months. The fall risk assessment dated 10/30/12 indicated the resident did not have a history of falls in the past 3 months.</p> <p>The resident's asmission nursing assessment dated 8/9/12 indicated under the bed rail safety assessment, bed rails were not indicated.</p> <p>The initial fall risk assessment dated</p>		<p>side rail screens and physician orders are properly completed. It has been added to the housekeeping checklist for discharge to have the current bed rails removed from the bed to ensure that the next resident admitted to the room has the appropriate device in place. The Director of Nursing will visually inspect all newly purchased side rails to ensure compliance. The side rails will be audited monthly for three months and presented to the QA committee. Audits will be complete when compliance is met at 100% for a full quarter.</p>		

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	<p>8/9/12 indicated no history of falls in the past 3 months.</p> <p>Review of resident #65's health care plan dated 8/9/12 indicated the problem as: at risk for falls. One of the interventions indicated "side rails to assist with bed mobility".</p> <p>An interview with the administrator on 4/19/13 at 2:30 P.M. indicated the side rail removed from resident #65's bed was 1/2 length. The administrator indicated the physician's order indicated 1/4 length bed side rails.</p> <p>An interview with RN #2 on 4/15/13 at 2:00 P.M. indicated she believed the resident did not have bed side rails and had no need for side rails.</p> <p>An interview with the DN on 4/18/13 at 10:15 A.M. indicated the removed siderail was removed on 4/15/13 and thrown into the trash. The DN indicated the resident was being reevaluated for use of bed side rails.</p> <p>3.1-19(c)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review, and interview, the facility failed to ensure non-pharmaceutical interventions were attempted prior to giving Anti-anxiety medications, for 2 of 10 residents reviewed for Unnecessary Medication Use, Resident #90, and Resident #47.</p> <p>Findings include:</p> <p>The record for Resident #90 was reviewed at 8:39 a.m., on 4/18/13.</p>	F000329	It is the practice of Warsaw Meadows Care Center to ensure that 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); for excessive duration; without adequate monitoring; or without adequate indications for use. Anti-anxiety and anti psychotic drugs will have gradual dose reductions and behavioral or non medication interventions, unless clinically contraindicated in an effort to discontinue the drug.	05/08/2013			

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	<p>Diagnoses included, but not limited to: Huntington's Chorea, subdural hematoma, dementia, depression, anxiety with behavioral disturbance, and mood disorder.</p> <p>Physician orders for April, 2013, indicated Lorazepam 1 milligram (mg) by mouth, three times a day as needed for anxiety.</p> <p>Review of the Medication Administration Record (MAR) for March, 2013, indicated Lorazepam was given twice on 3/30/13, at 8:00 a.m., and 12:00 p.m., for increased anxiety. Interventions of toileting and change of environment were attempted at 8:00 a.m., prior to giving the dose of Lorazepam, but no interventions were documented prior to giving the 12:00 p.m., dose of Lorazepam.</p> <p>The record for Resident #47 was reviewed, at 10:15 a.m., on 4/18/13. Diagnoses included, but not limited to: Senile Dementia, Dysphagia, depression, abnormality of gait, and dementia w behavioral disturbances.</p> <p>Physician orders for April, 2013, indicated Lorazepam 1 milligram, by</p>		<p>I. Resident #90 and resident #47 did not suffer any negative effects from medication use absent the documentation of interventions utilized prior to administration. Both residents had a recent GDR for anti psychotic medication and used an as needed anti anxiety to curb the side effects.</p> <p>II. Residents that utilize anti-anxiety medication have the potential to be affected.</p> <p>III. The facility has a behavior management policy in place. Licensed nurses and social service personnel have been re-educated on this policy on 04/22/2013. This re-education stressed the importance of the provision of non-drug interventions prior to implementing psychoactive medications; and the use of the behavior monitoring record. The facility has also implemented a flow sheet to be placed in the Medication Administration Record called prn psychotropic pre-med use interventions. This form, provided by Social Services, will list each resident's individual non-medication interventions. The nursing staff was educated on the PRN Psychotropic Pre Med use flowsheet on 04/21/2013.</p> <p>IV. In addition to the process noted above, the SSD or her designee is conducting a quality improvement audit to ensure residents are monitored prior to the initiation of anti-anxiety medications and that the</p>		

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	<p>mouth, every 6 hours as needed for agitation.</p> <p>Review of the Medication Administration Record for April, 2013, indicated the Lorazepam was used on 2 days, April 5, and April 11, 2013. On the back of the April MAR, documentation indicated the Lorazepam was given at 5:00 a.m., on 4/5/13, for increased anxiety, however there was no documentation any non-pharmaceutical interventions had been attempted prior to giving the medication.</p> <p>Although the front of the MAR indicated the Lorazepam was given on April 11, 2013, there was no documentation on the back of the MAR or in the nursing notes to indicate what time the Lorazepam was given, or any non-pharmaceutical interventions had been attempted prior to giving the medication.</p> <p>The Director of Nursing Services (DNS) was interviewed, at 9:30 a.m., on 4/19/13, and indicated the nurses were inserviced during orientation and periodically regarding attempting non-pharmaceutical interventions prior to giving a medication. She also indicated the social worker audited the records routinely to ensure staff were documenting interventions prior to giving PRN (as needed)</p>		<p>indications for use are documented. All residents receiving anti-anxiety medications on an as needed basis will be monitored weekly for 4 weeks, then monthly until 100% compliance is met for a full quarter. Results will be presented in Quality Assurance Meeting monthly.</p>				

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	<p>medications.</p> <p>Review of the policy for Medication Management, provided by the Director of Nursing Services, at 9:38 a.m., on 4/19/13, and reviewed at this time, indicated the following: "The physician prescribes the appropriate doses to be administered for an appropriate duration. Non-pharmaceutical interventions (i.e. for behavioral interventions) are considered before selecting a pharmaceutical intervention or are considered in concert with a pharmaceutical course of action."</p> <p>The Social Service Director was interviewed, at 9:44 a.m., on 4/19/13. She indicated normally audited charts and MARs weekly, but stopped auditing the "front" unit about 6 months ago because everyone was doing a good job.</p> <p>3.1-48(a)(1) 3.1-48(a)(3)</p>				

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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, interviews, and record review, the facility failed to</p>	F000441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD,	05/08/2013			

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	<p>follow the policy in regard to disinfecting the Blood Glucose Monitoring machine correctly. This deficiency affected 1 of 1 diabetic resident who received and was observed for Blood Glucose Monitoring (Resident #11)</p> <p>Findings include:</p> <p>On 4/18/13 at 11:45 a.m. LPN #1 was observed to use the Blood Glucose Monitoring machine to obtain a drop of blood from Resident #11's finger. LPN #1 did not clean the Blood Glucose Monitoring machine prior to obtaining the resident's blood. LPN #1 left the resident's room and set the Blood Glucose Monitoring machine on top of the medication cart. LPN #1 was observed to clean the Blood Glucose Monitoring machine with an alcohol prep pad. The Clorox wipes were observed to be on top of LPN #1's medication cart. Interview with LPN #1 indicated she was not aware she was suppose to clean the Blood Glucose Monitoring machine with Clorox wipes. LPN #1 indicated the diabetic residents did not have their own Blood Glucose Monitoring machines.</p> <p>The clinical record of Resident #11 was reviewed on 4/18/13 at 1:00 p.m.</p>		<p>LINENS</p> <p>It is the intent of Warsaw Meadows to 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>I. Resident #11 was not affected by this practice due to the fact that the machine was to be disinfected after the resident had received a glucometer check.</p> <p>II. This deficient practice has the potential to affect 19 residents in the facility who receives glucometer checks.</p> <p>III. LPN #1 was immediately in serviced on the proper procedure for cleaning glucometers, which includes instructions on the disinfectant wipes, "the surface shall remain visibly wet for 5 minutes." Licensed nursing staff was in serviced on 04/21/2013 on the appropriate cleaning of the glucometer by the Director of Nursing. All licensed nursing staff will have to pass a competency/return demonstration on proper technique for cleaning the glucometer with the Director of Nursing/designee by May 8 th , 2013.</p> <p>IV. The Director of</p>		

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	<p>and indicated Resident #11 had a diagnosis included, but were not limited to, diabetes.</p> <p>The Physician's Orders dated 2/13/13 indicated to check Resident #11 blood glucose level 4 times a day.</p> <p>The policy for Infection Control-Blood Glucose Machine Safe Injection Practices to Prevent Resident to Resident Transmission of Bloodborn Pathogens was received from the Director Nursing Services on 4/18/13 at 1:45 p.m. and indicated "3. Be sure to clean and disinfect the blood glucose machine environmental surface with Clorox- wipes before and after testing the resident's blood glucose..."</p> <p>On 4/19/13 at 9 a.m. the Director Nursing Service was interviewed in regard to the Blood Glucose Monitoring machine and indicated LPN #1 should had cleaned the Blood Glucose Monitoring machine with a Clorox wipe before and after the machine was used on the resident.</p> <p>Review of the undated CDC (Centers for Disease Control) guidelines included, but were not limited to: Clean Blood Glucose Monitoring machine with an antiviral product that</p>		<p>Nursing/Designee will observe the licensed staff for proper procedure and cleaning of the glucometer twice weekly for one month then monthly for 2 months. Quarterly thereafter until compliance is met at 100% for a full Quarter. Results will be shared monthly by the QA committee monthly.</p>				

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	will kill HIV and HCV (Hepatitis C Virus). 3.1-18(b)(1)				