

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER ROO-LAN HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTHEAST CARPENTER ROAD LACEY, WA 98503	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Roo-Lan Healthcare Center on 06/04/12, 06/05/12, 06/06/12, 06/07/12 and 06/08/12. The survey included data collection on 06/06/12 from 7:30 p.m. to 9:30 p.m. A sample of 43 residents was selected from a census of 92. The sample included 37 current residents and the records of 6 former and/or discharged residents.</p> <p>AMENDED PER IDR 7/30/12</p> <p>The survey was conducted by:</p> <p>Sonya Conway, MSW Susan Henderson, RN, BSN Liz Frost, MSN, RN Alicia Contreras, RN, BSN Amy Abbott, LICSW Jeri Jones, BSN, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3, Unit C & D P.O. Box 45819 Olympia, Washington 98504-5819</p> <p>Telephone: 360.664.8420 Fax: 360.664.8451</p>	F 000	<p>The submission of this plan of correction does not constitute admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law.</p> <p>Please accept this submission of the plan of correction as our allegation of substantial compliance effective, May 2nd, 2007.</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>		TITLE <i>[Signature]</i>		(X6) DATE 8/20/2012

RECEIVED
AUG 30 2012
DSHS/ADSA/RCS

[Signature] 8-23-12 for IDE Program Manager
Residential Care Services Date

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

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F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>Correction as it relates to the resident: Resident's #111 and #127 have discharged from the facility.</p> <p>Resident #121 and her Guardian will be presented with the most recent Medicare form used to notify Resident's, Families and Guardian's of the end of skilled services and their appeal rights.</p> <p>Action taken to protect residents in similar situations: An audit of facility resident's having received Medicare end of skilled service and appeal forms from January 1st 2012 to present will be completed. New Medicare forms will be issued if it is found that facility is out of compliance with the current edition of the Medicare form.</p> <p>Measures taken or systems altered to ensure the problem does not recur:The Business Office Manager will sign up to receive Medicare News Letters and will check the Medicare website at the beginning of each month to ensure new information such as form changes are implemented.</p> <p>Audits of issued Medicare Letters to Resident's, Families and Guardians will be completed monthly by the BOM or designee.</p>	

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F 156	<p>Continued From page 2</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's</p>	F 156	<p>Plans to monitor performance to ensure solution is sustained: Audits will be submitted to the Quality Assurance Committee or review and recommendation.</p> <p>Title of Person Responsible for Compliance Director of Nursing Services and Administrator</p> <p>Date of compliance: August 1st, 2012</p>	
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F 156	<p>Continued From page 3</p> <p>policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the appropriate liability and appeal notices for 3 of 3 sampled residents (#111, 121 & 127) reviewed. This failure placed residents at risk for not being fully informed about their legal rights, and not have the opportunity to exercise their rights to disagree with discharge from skilled services.</p> <p>Finding include: <Liability and Appeal Notices> On 06/05/12, the records of 3 residents (#111, 121, and 127) were reviewed to ensure they were given notice that their Medicare skilled services were ending. All three had been given notice on an outdated Medicare form. The form offered residents three options to choose from. One of the options indicated that the resident could pay the facility immediately while the appeal was in process.</p>	F 156		

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F 156	Continued From page 4 At 3:06 p.m., when asked the Business Office Staff (BOS) if residents would be billed during the appeal process. BOS A replied, "Yes." The request for payment during the appeal process was a violation of Medicare regulation. The facility's liability and appeal notice forms were not current at the time of the survey.	F 156		
F 241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide an environment which promoted the dignity of residents in 1 of 2 dining rooms observed for dining service. This failure to recognize and respond to residents in a manner that promoted a sense of dignity placed residents at risk for diminished self-esteem and a decreased quality of life. Findings include: On 06/04/12 at 12:06 p.m., staff was observed in the assistive dining room placing clothing protectors on residents without asking permission. On 06/04/12 at 12:39 p.m., staff in the second sitting of the main dining room were observed	F 241	Correction as it relates to the resident: No specific Resident's were names in this deficiency. Action taken to protect residents in similar situations: The Roolan Interdisciplinary Team has been re-educated to the importance of involving the Resident's in choices of apparel such as clothing protectors to maintain an environment that fosters dignity and respect for the individual.	

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F 241	Continued From page 5 placing clothing protectors on residents without asking residents if they wanted to have one. At 12:51 p.m., a dependent/nonverbal resident was observed to have a clothing protector placed on him without staff asking. On 06/06/12, during the lunch meal, staff were observed, during the first and second sittings of the main dining room, placing clothing protectors on residents without asking the residents if they wanted it. Residents were observed having a clothing protector placed on them without the staff acknowledging the resident. On 06/06/12 at 9:12 p.m., the Social Services/Assistant Administrator indicated the staff should ask the residents if they want a clothing protector.	F 241	Measures taken or systems altered to ensure the problem does not recur: Audits of the dining room experience will be completed by the Dietary Manager and designees to assure that staff comprehend the importance of resident dignity and choice. Plans to monitor performance to ensure solution is sustained: Audits will be submitted to the Quality Assurance Team for review and recommendation. Title of Person Responsible for Compliance Director of Nursing Services and Administrator Date of compliance: August 1 st , 2012	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		

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F 279	<p>Continued From page 6</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to review and revise a comprehensive plan of care that included specific interventions for all staff to utilize in the management and treatment of behavioral, mental and/or emotional symptoms for 1 of 19 current sample residents (#52) reviewed for care plans. This placed the resident at risk for not receiving consistent care from all staff.</p> <p>Findings include:</p> <p>Resident #52 was readmitted to the facility on [REDACTED] with diagnoses of [REDACTED]</p> <p>The annual Minimum Data Set (MDS), an assessment tool, dated 12/22/11, identified the resident as an interviewable candidate. The mood section was completed with resident input and reported that nearly every day the resident had "trouble sleeping and concentrating," and "moving and speaking so slowly you think others notice."</p> <p>The most recent care plan, updated in March 2012, indicated a problem of "alteration in thought process and mood, has diagnosis of depression and anxiety... She can be manipulative where she loves staff one minute and throws threats out</p>	F 279	<p>Correction as it relates to the resident:</p> <p>A behavior management meeting was held with members of the interdisciplinary team <i>from all shifts to share and discuss actions and interventions that are used during care to provide comfort, ease anxiety, encourage participation in care and de-escalate angry/frustrated behavior of Resident #52. Successful interventions were compiled and listed on a "Tips for Behavior Management" sheet in front of the Care Directive for Resident #52</i></p> <p>Action taken to protect residents in similar situations:</p> <p>The resident population was assessed for those whose behaviors presented challenges when delivering care. Behavior management meetings will be held to share and discuss actions and intervention that employees have found to work, or not work in relation to our Resident's. A "Tips for Behavior Management" sheet <i>will be placed in front of resident's care delivery sheets as applicable.</i></p>	

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F 279	<p>Continued From page 7</p> <p>about calling the state. She does self-isolate with curtain around her bed at times. She decides who she wants to interact with..." The goals for this problem included decreased signs and symptoms of depression with current prescription, will attend 1-2 out of room activities per week, resident will refrain from using profanities when speaking of others, decrease signs and symptoms of anxiety, restlessness, excessive worrying with prescription and will decrease verbal manipulation of staff.</p> <p>The interventions for staff to utilize when assisting resident with this problem included interventions for activities staff to offer music, games, pet visits, and reading. The Licensed Nurse was to offer as needed (prn) [REDACTED] (an anti-anxiety medication) after offering fluids, food, and a quiet environment. Social Services was to observe mood on rounds, have an open door policy, observe resident interactions with roommates as has been known to be rude, encourage her to do activities, resident comes to office to vent and to indulge her sense of humor.</p> <p>No individualized interventions, which included measurable objectives with time tables to meet the resident's needs related to behaviors, were documented on the care plan or nursing care directive. The objectives are for unlicensed staff to use when the resident became manipulative, anxious, upset, depressed, made self-deprecating comments, or started cussing during care.</p> <p>On 06/06/12 at 2:34pm, the lack of interventions on the care plan or care directive for floor staff to use was discussed with the Director of Nursing Services (DNS) and Social Services/Assistant</p>	F 279	<p>Measures taken or systems altered to ensure the problem does not recur: Residents will be reviewed by the <i>interdisciplinary team upon admission and with each MDS assessment to assess whether they and staff would benefit from a "Tips for Behavior Management" sheet.</i> The Social Service Department will be responsible for initiating, updating and auditing the behavior management sheets as necessary during care conferences.</p> <p>Plans to monitor performance to ensure solution is sustained: Audits will be submitted to the Quality Assurance Committee for review and recommendation.</p> <p>Title of Person Responsible for Compliance Director of Nursing Services and Administrator</p> <p>Date of compliance: August 1st, 2012</p>	

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F 279	Continued From page 8 Administrator (SS/AA). The DNS stated, "We have intellectual staff," and they received a long orientation where they are taught how to deal with each resident. The DNS also stated the interventions do not have to be "spelled out step by step on what to do." The DNS reported if problems occur, the staff can come to her, or SS/AA, for assistance. When asked about night shift, a time when most of the prn [REDACTED] was used, the DNS stated, "I'm on-call 24/7 and they can call me" and "the problem will be dealt with the next morning."	F 279		
F 282 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure specialized mental health services were provided per the written care plan for 2 of 19 current sampled residents (#138 & 91) reviewed for care plans. This failure placed residents at risk for decreased quality of life by not receiving specialized services in a timely manner. Findings include: <Resident # 138> Resident #138 was admitted to the facility on	F 282	Correction as it relates to the resident: Resident's #91 and #138 had PASSR evaluations completed and submitted to the PASSR evaluation center for review and recommendation. Resident # 91 has agreed to Mental Health services and is awaiting evaluation. His care plan has been updated to reflect problems, goals and approaches related to his mental health care needs. Resident #138 had been active with a Mental Health Practitioner of her choosing prior to admission and wishes to continue. Her care plan has been updated to reflect problems, goals and approaches related to her mental health care needs.	

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F 282

Continued From page 9
 [REDACTED] with diagnoses to include [REDACTED]
 [REDACTED]

The resident's admission Minimum Data Set (MDS), an assessment tool, dated 05/04/12, documented she had a mental health disorder.

The resident's Preadmission Screening and Resident Review (PASSR), dated 04/26/12, signed by the physician, indicated the resident had a diagnosed mood disorder. The PASSR documented Level II specialized mental health services were required.

On 06/06/12 at 8:44 a.m., the Social Services/Assistant Administrator (SS/AA) stated she had been talking with persons outside the facility to provide the services, and that she did not document it in the chart. She stated she had a fax to the physician. When the SS/AA was asked for a copy of the fax, she said she had "just thinned it out and threw it away." When asked why she did not use the resident's medical record to document the attempts to provide the services for the resident, she stated she has her own system and "quite possibly she (Resident #138) got missed."

<Resident #91>

Resident #91 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]
 [REDACTED]

A PASSR, dated 03/17/12, documented the

F 282

Action taken to protect residents in similar situations:
 A resident population audit has been completed to assure no other resident's have missed PASSR evaluations with follow up as recommended. The interdisciplinary team has been educated to the intricacies of the PASSR evaluation process and how to proceed in assisting the Social Service department to maintain resident evaluation and treatment as needed. Care plans have been adjusted accordingly to address our resident's mental health care needs.

Measures taken or systems altered to ensure the problem does not recur:
 Upon admission -

1. Resident's with a positive PASSR review will have the review sent to the PASSR evaluation center for review and recommendation and care planning process for mental health needs initiated.
2. Those Resident's who are admitted without a PASSR review will have one completed by the Social Service Director or designee. Positive screens will be sent to the PASSR evaluation center for review and recommendation and care planning process for mental health needs initiated.
3. Auditing of the PASSR and care planning process will occur at the initial Resident Care Conference to assure that PASSR evaluations have been completed, received by the PASSR evaluation center and that recommendations and care planning are in process.

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F 282	Continued From page 10 resident required Level II specialized services as determined by the physician. The medical record was reviewed. There was no documentation the resident had been assessed or services had been obtained. On 06/06/12 at 11:02 a.m., when asked about Resident #91 and his PASSR needs determined by the physician, the SS/AA stated, "He is another resident that was missed and has yet to be evaluated." Refer to F 406	F 282	Plans to monitor performance to ensure solution is sustained: Audits of the PASSR and care planning process for Resident's with mental health needs will be submitted to the Quality Assurance Committee for review and recommendation. Title of Person Responsible for Compliance Director of Nursing Services, Social Service Director and Administrator Date of compliance: August 1 st , 2012 -----		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 19 current sampled residents (#121) received the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care regarding her medical condition. This failure placed residents at risk for harm from not having, adequate pain	F 309	Correction as it relates to the resident: Pain Management – Resident #121 has been assessed for discomfort to right ankle. She is adamant that she has no pain or discomfort to right ankle yet she wishes to continue one Tylenol 325mg per day after lunch. We have requested a routine Tylenol order. Action taken to protect residents in similar situations: Pain and Specialized Medical Assessment – Both issues described in the deficiency for resident #121 have to do with noting, communication and documentation of a consultant recommendation or order.		

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PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER ROO-LAN HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTHEAST CARPENTER ROAD LACEY, WA 98503	
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F 309	<p>Continued From page 11 management and a specialized medical examination identified.</p> <p>Findings include:</p> <p>< Pain Management ></p> <p>Record review of an orthopedic physician visit, dated 03/30/12, documented, "displaced pubic ramus fracture, right medial malleolus (ankle) fracture. Follow-up in 3 months unless she complains of new problems." The orthopedic specialist documented he should be notified if the resident experienced pain after starting rehabilitation.</p> <p>The resident's MDS, dated 4/08/12, documented the resident had frequent vocalizations of pain.</p> <p>On 06/06/12, CN A stated the resident had started rehab so that was probably why she began to complain of increased pain in April 2012. CN A acknowledged there was no notification of the orthopedic physician to report the resident had requested multiple doses of pain medication over two months time</p> <p>Record review of the resident's Medication Administration Record (MAR) found the following: Tylenol (a non-narcotic pain reliever) was given to the resident PRN (as needed) in April for 21 times when the resident complained of foot and leg pain and 11 times in May 2012 for foot pain and/or general pain. Record review of the resident's medical chart found no physician notification of increased pain in April and May 2012.</p>	F 309	<p>Licensed Nurses have been educated to the correct procedure for noting, communicating and documenting physician or consultant recommendations to assure that specialized medical assessment is provided.</p> <ol style="list-style-type: none"> 1. LN to sign and date document as noted. 2. LN to inform primary physician and resident's responsible party of consultant recommendation. 3. LN noting recommendation is to route necessary information to other team members so that they can participate in the assessment of the resident and referrals to specialized services as necessary. For example: An orthopedic consultant note stating to follow up in 3 months or sooner if resident has new issues or increased discomfort to lower extremity should be routed to the medication nurse as well as rehab department so that they can assess for new issues or discomfort during resident care. 4. Finally, if the resident, responsible party or physician have a difference in opinion from the consultant and choose not to follow the recommendation or postpone it this needs to be documented thoroughly in the residents medical record. <p>Measures taken or systems altered to ensure the problem does not recur: The Medical Records Director will audit all consultant reports when filing to make sure all components of noting a consultant or physician recommendation are completed properly.</p>	

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F 309 Continued From page 12
There was no evidence in the medical record the facility notified any physician of the resident's complaints of ankle/foot pain.

F 325 483.25(i) MAINTAIN NUTRITION STATUS
SS=D UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to maintain acceptable parameter of nutritional status (body weight) for 1 of 3 current sampled residents (#120) reviewed for nutrition. This failure placed the residents at risk for harm related to weight loss.

Findings include:
Resident #120 was admitted to the facility on [redacted] with diagnoses to include [redacted]

At 1:37 p.m., Resident #120 was observed attempting to self propel his wheel chair. His cheeks were sunken in, his arms and hands were

F 309 **Plans to monitor performance to ensure solution is sustained:** Audits of consultant reports will be submitted to the Quality Assurance Committee for review and recommendation.
Title of Person Responsible for Compliance: Director of Nursing Services and Administrator **Date of compliance:** August 1st, 2012

Correction as it relates to the resident:
Resident #120 receives whole milk and fortified meal items with each meal. He also receives a magic cup twice a day, (calorie dense ice cream type supplement). Nursing Staff offer resident 120mls of 2cal, a calorie dense sweet drink, three times a day during medication administration.

Resident's physician visited and prescribed [redacted] an antidepressant that has appetite stimulating properties. Resident continues to eat 100% of breakfast, (sometimes two breakfasts) and usually over 75% of lunch and dinner meal.

Dietary and nursing staff will continue to offer fortified, high calorie and nutritious meals, snacks and supplements throughout the day, evening and night when awake.

Action taken to protect residents in similar situations:
Residents receive either weekly or monthly weights. Weights are reviewed weekly by the DNS, Dietary Manager and RD. Those residents with weight loss are referred to the RD for evaluation and recommendation.

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F 325	<p>Continued From page 13</p> <p>thin, the bones in his hands prominent. His shirt and pants were loose and hung. He appeared as the RD 's 04/13/12 observation, "underweight per subjective appearance."</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 04/22/12, documented the resident was moderately cognitively impaired, required limited assistance of one staff person for eating, and had complaint(s) of "difficulty or pain with swallowing."</p> <p>The resident's MDS, dated 04/29/12, documented the resident had weight loss of 5% of total body weight in the last month or 10% total body weight loss in the last 6 months.</p> <p>The resident was documented as not being on a physician prescribed weight loss plan or documented as at risk for malnutrition.</p> <p>On 04/06/12, the Registered Dietician (RD) documented on the Dietary Progress Note, the resident's wife requested he receive a high protein supplement. The RD documented the resident was at risk for weight loss and was with increased caloric and protein needs related to his fracture. The RD documented it was appropriate to add the requested supplement, recommended a "magic cup" (a high calorie ice cream like supplement), and for the RD to follow up with a full assessment.</p> <p>On 04/13/12, a Nutrition Assessment documented the resident's 4/11/12 weight was 130 lbs, down from a 4/8/12 recorded weight of 134.4 lbs. It documented the resident had increased nutritional needs, and considered a</p>	F 325	<p>Physicians and families are notified. The facility uses a variety of techniques to help increase and stabilize weight when possible. These are offered throughout the day with the understanding that residents with weight loss have vacillation in their appetite and intake.</p> <p>Measures taken or systems altered to ensure the problem does not recur: The DNS and Dietary Manager will audit resident weights and resident supplements weekly to assure that proper supplements are implemented for those with weight loss.</p> <p>Plans to monitor performance to ensure solution is sustained: Audits will be submitted to the Quality Assurance Committee for review and recommendation.</p> <p>Title of Person Responsible for Compliance Director of Nursing Services and Administrator</p> <p>Date of compliance: August 1st, 2012</p>	
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F 325	<p>Continued From page 14</p> <p>nutritional risk. Recommendations were to add whole milk with meals, fortified cereals, and give a magic cup with lunch and dinner.</p> <p>On 04/19/12, a physician order was obtained for the resident to receive 2 cal nutritional supplement. The order directed to give the resident 120 cc (4 ounces) three times a day.</p> <p>On 05/05/12, a month after his admit, the resident's documented weight was 124 lbs. His 04/06/12 weight was documented as 135 lbs. The resident had a 11 lb weight loss, sustaining a total body weight loss of 8.14%.</p> <p>On 06/05/12, at 11:34 a.m., Charge Nurse (CN) A stated the resident was receiving a high protein, high calorie supplement, but it "didn't count because they (the facility) don't document how much he drinks of it."</p> <p>On 06/06/12 at 12:41 p.m., Licensed Nurse (LN) B was asked if the Medication Administration Record (MAR) recorded the quantity of the supplement the resident drank. He replied, "No, it just shows whether we gave it or not." When asked how the facility could verify the resident was receiving the quantity of 120cc three times daily as directed by the physician, he stated, "Well, I guess we really can't." When asked how much the resident usually drank of his supplement, he stated it "varied."</p>	F 325		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	<p>Continued From page 15</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>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify the indication for use of prescribed medications; monitor for adverse effects and/or effectiveness of medications and/or perform Gradual Dose Reduction (GDR) of psychotropic medications for 4 of 11 current sampled residents (# 52, 49, 64, & 121) reviewed for unnecessary drug use. These failures placed the residents at potential risk of receiving unnecessary medications, not receiving effective</p>	F 329	<p>Correction as it relates to the resident:</p> <p>Resident #49 The resident's physician and family were notified of need to consider taper of psychotropic medication. Family disagrees with trial of titration as this has been done in past with negative effects and suicidal ideation. The physician is in agreement with family. No taper initiated.</p> <p>Resident #52 Resident, Physician and Mental Health Practitioner discussed taper of psychotropic medications. Resident does not wish to taper her [REDACTED] or [REDACTED] dosage or change to an alternate medication at this time. The physician does not wish to taper or discontinue the [REDACTED] as residents blood sugars have stabilized as well as her HgA1C. Physician did discontinue the order for Tylenol. Physician was educated not to write orders in the physician notes but to place them in the physicians order portion of the medical record.</p> <p>Resident#64 Physician consulted regarding Vitamin D dosage and lab values. He does not wish to change dosage or draw labs at this time.</p> <p>Resident #121 Physician titrated [REDACTED] on 6/8/12 from three times a day to two times per day. Trial reduction failed and [REDACTED] was increased back to three times per day on 6/18/12.</p> <p>Action taken to protect residents in similar situations: A new tracking system has been put in place to assure that psychotropic medications are assessed each quarter in conjunction with the MDS and resident care conference.</p>	

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F 329	<p>Continued From page 16 treatment from medications and/or not monitoring side effects from medications.</p> <p>Findings include:</p> <p><Resident #64></p> <p>Resident #64 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>On 09/01/10, a physician order documented the resident was to receive 4,000 international units (iu) of vitamin D daily as a supplement, without an identified diagnosis for use.</p> <p>The medical record showed there was no evidence of the resident's vitamin D level being monitored.</p> <p>On 06/06/12 at 9:48 a.m., the Assistant Director of Nursing (ADON) was asked about the facility policy of monitoring vitamin D levels. The ADON stated, "It is not being checked regularly because Medicare does not pay for it." When asked how the facility monitors the resident's vitamin D levels to avoid potential toxicity, the ADON stated, "It is a supplement and residents are given a good RDA (recommended dietary allowance) dose so there shouldn't be a problem. The MD would have it checked if he wanted," but it is "not checked regularly."</p> <p>According to the Mayo Clinic and the Natural Standard Research Collaboration, last updated 10/1/11, the Institute of Medicine (IOM) has</p>	F 329	<p>The physician and responsible party will be notified of the need to trial titrations of these medications at least every six months unless titration has been attempted in the past and resulted in negative outcomes. In this case the physician order will be noted with LEAST EFFECTIVE DOSE -- CLINICALLY CONTRAINDICATED TO CHANGE.</p> <p>In reference to other medications deemed unnecessary in this deficiency, the pharmacy consultant visits every month and will comprise a letter directed to the physician of those medications he feels may be unnecessary. The facility staff will route these to the physician for review and orders per physician's wishes. Please refer to deficiency F-157.</p> <p>Measures taken or systems altered to ensure the problem does not recur: Audits of the new tracking system for titration of medications will be completed by the MDS Coordinator and DNS. Audits of the pharmacy recommendation system will be completed by the Medical Records Department.</p> <p>Plans to monitor performance to ensure solution is sustained: Audits will be submitted to the Quality Assurance Committee for review and recommendation.</p> <p>Title of Person Responsible for Compliance: Director of Nursing Services and Administrator</p> <p>Date of compliance: August 1st, 2012</p>		

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IDR A-11-0000

PRINTED: 08/23/2012
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OMB NO. 0938-0391

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F 329	<p>Continued From page 17 reviewed and updated the Dietary Reference Intakes (DRIs). The new recommended daily allowance (RDA), as set in 2010, is based on age. For those 71 years and older, 800 IU daily is recommended. The IOM further recommended that serum levels > 50ng/mL (= 125 nmol/L) could have potential adverse effects.</p> <p><Resident #49></p> <p>Resident #49 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>On 11/29/11, the physician prescribed the resident an antipsychotic, [REDACTED] 0.5 mg by mouth twice daily.</p> <p>On 12/15/11, the Registered Pharmacist (RPH) recommended Resident #49 taper off [REDACTED]. There was no evidence in the resident's medical record that the facility notified the physician to consider that taper.</p> <p>On 6/5/12, at 1:24 p.m., the Director of Nursing Services (DNS) stated the facility Behavioral Management Team (BMT) meets every 6 months to discuss residents who are receiving anti-psychotics to discuss gradual dose reductions (GDR).</p> <p>The resident's medical record indicated the BMT notes did not document an attempt to reduce [REDACTED] after an order to increase it was given on 09/12/11.</p>	F 329	<p>Correction as it relates to the resident: Resident's #91 and #138 had PASSR evaluations completed and submitted to the PASSR evaluation center for review and recommendation. Resident # 91 has agreed to Mental Health services and is awaiting evaluation. Resident #138 had been active with a Mental Health Practitioner of her choosing prior to admission and wishes to continue.</p> <p>Action taken to protect residents in similar situations: A resident population audit has been completed to assure no other resident's have missed PASSR evaluations with follow up as recommended. The interdisciplinary team has been educated to the intricacies of the PASSR evaluation process and how to proceed in assisting the Social Service department to maintain resident evaluation and treatment as needed.</p> <p>Measures taken or systems altered to ensure the problem does not recur: Upon admission -</p> <ol style="list-style-type: none"> 1. Resident's with a positive PASSR review will have the review sent to the PASSR evaluation center for review and recommendation 2. Those Resident's who are admitted without a PASSR review will have one completed by the Social Service Director or designee. Positive screens will be sent to the PASSR evaluation center for review and recommendation. 	

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F 329	<p>Continued From page 18</p> <p>On 01/04/12, a BMT document described what dose of [REDACTED] the resident received. It did not document the resident's behaviors, response to the medication, whether a dose reduction was discussed as appropriate, or if the physician was aware of the resident's status.</p> <p>At 1:27 p.m., the DNS was asked to review the BMT documentation since September 2011 to see if documentation to support the pharmacist's recommendation for GDR was communicated to the physician. After reviewing the resident's medical record, the DNS stated, "No, it doesn't." <Resident #121></p> <p>Resident #121 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>Record review of physician orders, dated 01/13/12, noted the resident had orders to receive [REDACTED] (an anti-anxiety medication) 0.25 mg by mouth three times a day and as needed for severe anxiety and exit-seeking behaviors. She was also prescribed [REDACTED] (an anti-psychotic medication) 5 mg each day at bedtime.</p> <p>According to the Beers' Criteria, [REDACTED] ([REDACTED]) is a potentially inappropriate medication that may cause serious side effects for older adults including dizziness, weakness, and unsteady gait placing the resident at risk for falls (referenced from the American Geriatrics Society 2012).</p>	F 329	<p>Continue..</p> <p>3. Auditing of the PASSR process will occur at the initial Resident Care Conference to assure that PASSR evaluations have been completed, sent and received by the PASSR evaluation center and that recommendations are in process.</p> <p>Plans to monitor performance to ensure solution is sustained: Audits of the PASSR process will be submitted to the Quality Assurance Committee for review and recommendation.</p> <p>Title of Person Responsible for Compliance: Director of Nursing Services and Administrator</p> <p>Date of compliance: August 1st 2012</p>	

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F 329	<p>Continued From page 19</p> <p>Record review of a pharmacy review note, dated 05/21/12, documented the pharmacist recommended the facility begin tapering the use of [REDACTED]</p> <p>Review of the resident's facility chart found no attempt at dose reduction or documentation regarding a reason to not attempt dose reduction as of 06/07/12. There was no documentation that the physician had been notified of the pharmacist's recommendation to begin an [REDACTED] taper.</p> <p>On 06/07/12 at 2:26 p.m., the DNS indicated the facility had not given the May 2012 pharmacy recommendations to the physician as of 6/07/12.</p> <p><Resident #52></p> <p>Resident #52 was readmitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>1) A review of the medical record revealed a physician's (MD) note, dated 3/21/12, to "monitor LFTs (lab monitoring liver function) every 6 months and no Tylenol related [REDACTED]" There was no documentation in the resident's record indicating the lab was drawn. The resident continued to receive as needed (prn) Tylenol. Charge Nurse A nurse's note, dated 3/21/12, indicated the MD's progress note was reviewed. Medication administration record (MAR) review showed the resident received Tylenol 2 days in June, 14 days in May, and 10 days in April.</p> <p>On 06/7/12, the DNS stated the MD's progress</p>	F 329		

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F 329	<p>Continued From page 20</p> <p>notes are "usually done (reviewed) while here so we know what they contain." She indicated the nurses talk with the MD to find out what was done during the visit. When asked about the MD note from 03/21/12, the DNS stated, "We will educate this MD as she cannot just expect us to find it in the chart. I don't know how it was not reviewed."</p> <p>2) Review of Resident #52's record showed two different prn MD orders for [REDACTED] (an anti-anxiety medication). One order read [REDACTED] 0.5 milligrams (mg) three times a day prn and the other read [REDACTED] 1mg three times a day prn. There were no parameters of when to administer the 0.5mg dose versus the 1mg dose. The orders gave non-pharmacological interventions to try before the prn [REDACTED] administered.</p> <p>In June, the prn [REDACTED] 0.5mg dose was administered three times and the prn 1mg dose was given three times. In May, the resident received prn [REDACTED] 1mg on 2 days and prn [REDACTED] 0.5mg on 19 days. In April, [REDACTED] 0.5mg was administered on 13 days for 15 doses. The majority of the prn usage was between the hours of midnight and 4.00 a.m.</p> <p>The psychoactive medication monitoring sheet in the MAR was not documented on prior to each prn use. The behavior tracking document was completed only 13 days between April - June 2012.</p> <p>On 06/06/12 at 2:12pm, Licensed Nurse (LN) B stated he determined which dose of [REDACTED] to give the Resident was dependent "on how agitated she is and believe me you would know," "like a 1-10 pain scale and when asked and she yells at</p>	F 329		

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F 329	<p>Continued From page 21</p> <p>you it's a 10." When LN B asked if there were parameters for administrations of prn [REDACTED] he looked at the MAR and stated, "I guess not." He added the resident asked for the dose she wanted. LN B acknowledged there were interventions to try before prn usage and reviewed the psychoactive medication monitoring sheet form and stated, "it's supposed to be checked." When asked to clarify the time frame for the prn orders, he indicated she could have each dose every 8 hours with at least 1 hour between the different doses.</p> <p>On 06/06/12 at 9:00pm, Resident #52 reported she has taken [REDACTED] for years for anxiety. "I used to take a whole one but now I only use half." When asked what dose she requested in the event of increased anxiety she stated, "I only have half, that changed a long time ago" (clarified she was referring to half a milligram dose).</p> <p>The pharmacy reviews for Resident #52, dated 12/2011 and 03/2012, recommended a taper of her [REDACTED] (an anti-anxiety medication). There was no documentation in the medical record indicating the pharmacy recommendation regarding the [REDACTED] was communicated to the physician or the [REDACTED] taper was attempted. The resident continued to receive [REDACTED] as ordered.</p> <p>3)The pharmacy reviews for Resident #52, dated 04/2012 and 05/2012, recommended discontinuing [REDACTED] (a medication to control blood sugar levels). There was no documentation in the medical record that the MD was notified of the recommendation. The resident continued to receive [REDACTED] as ordered.</p>	F 329		
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F 406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure specialized mental health services were provided in a timely manner for 2 of 7 current sampled residents (#138 & 91) identified as needing Level II mental health services on the facility Pre-admission Screening and Resident Review (PASSR). This failure placed the residents at risk for diminished quality of life, and increased negative mental health issues.</p> <p>Findings include: <Resident # 138></p> <p>Resident #138 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>The resident's admission Minimum Data Set (MDS), an assessment tool, dated 05/04/12,</p>	F 406		

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F 406	<p>Continued From page 23</p> <p>documented she had a mental health disorder.</p> <p>The resident's PASSR, dated 04/26/12, signed by the physician, indicated the resident had a diagnosed mood disorder. The PASSR documented the physician determined Level II specialized mental health services were required.</p> <p>On 06/06/12 at 8:41 a.m., Charge Nurse (CN) B stated if there was documentation that the resident received specialized services it would be done by the Social Services/Assistant Administrator (SS/AA) and would be documented under assessments. There was no documentation in the assessments, nursing, progress, physician progress or social services section of the medical chart the resident had received Level II services.</p> <p>At 8:44 a.m., the SS/AA stated she had been talking with persons outside the facility to provide the services, and that she did not document it in the chart. She stated she had a fax to the MD. When asked for a copy of the fax, the SS/AA stated she had "just thinned it out and threw it away." When asked why she did not use the resident's medical record to document the attempts to provide the services for the resident, the SS/AA stated she "has her own system" and "quite possibly she (Resident #138) got missed."</p> <p><Resident #91></p> <p>Resident #91 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p>	F 406		

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F 406	Continued From page 24 A PASSR, dated 03/17/12, documented the resident required Level II specialized services. The medical record showed there was no documentation the resident had been assessed or services had been obtained. At 11:02 a.m., the SS/AA was asked about Resident #91 and his PASSR needs determined by the physician. The SS/AA stated, "He is another resident that was missed and has yet to be evaluated." Refer to F 406	F 406		
F 431 SS=F	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 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. 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. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		

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F 431	<p>Continued From page 25</p> <p>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>This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure drugs and biologicals were properly labeled and stored in accordance with currently accepted professional principles in 5 of 6 medication/treatment carts. This failure placed residents at risk for receiving incorrect medications, dosages or contaminated items.</p> <p>Findings include: On 06/07/12 at 2:44 p.m., medication carts A & B were observed with Licensed Nurse (LN) B.</p> <p>The A wing cart had a bottle of tetrahydrozoline 0.05% eye drops. There was a sticker on the bottle that read "house supply" and a handwritten name, "██████████." There was no label to correctly identify the resident who was to receive the medication, or a label with instructions of how the medication was to be dispensed to the resident.</p>	F 431	<p>Correction as it relates to the resident: The facilities medication and treatment carts have been inspected and all <i>improperly labeled, stored or outdated</i> medication and treatment supplies have <i>been destroyed.</i></p> <p>Action taken to protect residents in similar situations: Re-education has been mandated for the <i>facilities licensed nurses to assure that they understand their responsibilities in maintaining properly labeled, stored and dated medications and treatment supplies in accordance with currently accepted professional principles.</i></p> <p>Measures taken or systems altered to ensure the problem does not recur: Medication and treatment carts will be inspected weekly by the facilities charge nurses or designees as appointed by the Director of Nursing Services to assure medication and treatment supplies are labeled, stored and dated appropriately.</p> <p>The facilities Pharmaceutical Consultant will inspect the medication and treatment carts no less that quarterly to assure the facility is maintaining proper labeling, <i>storing and dating of medication and treatment supplies.</i></p> <p>Plans to monitor performance to ensure solution is sustained: Inspections of medication and treatment carts will be submitted to the DNS as well as Quality Assurance Committee for review, recommendation or disciplinary action as needed.</p>	
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F 431	Continued From page 27 bottles of house supply artificial tear eye drops with no resident names or labels that directed how the resident was to receive the eye drops or when the bottles had been opened. There were two observed bottles of Timolol, prescriptive eye drop medicine, with no labels directing how the residents were to receive the medication.	F 431		
F 441 SS=D	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. (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. (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	F 441		

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F 441	<p>Continued From page 28 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>This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure proper infection control techniques were used during 2 of 51 observed medication administrations. These failures placed residents at risk for infection and receiving contaminated medication.</p> <p>Findings include:</p> <p>On 06/06/12 at 11:40 a.m., Licensed Nurse (LN) A was observed preparing medications to give to Resident #1. The resident was to receive a calcium carbonate tablet. As LN A attempted to shake a tablet into the medication cup, the tablet got stuck in the neck of the bottle. LN A used her ungloved finger to slide the tablet into the medication cup.</p> <p>At 2:37 p.m., the Infection Control Nurse stated the staff were not to touch the resident's medication tablets with their bare hands.</p> <p>On 06/07/12 at 9:07 a.m., LN B was observed preparing medication for Resident #62. The resident was dispensed a vitamin D tablet from the house supply medication. As LN B dispensed</p>	F 441	<p>Correction as it relates to the resident: Resident #1 and #62 have been assessed and have suffered no infections in regard to receiving contaminated medications.</p> <p>Action taken to protect residents in similar situations: Licensed Nurses A and B and their peers have been re-educated to the proper infection control techniques used during medication administration that are required to prevent infection and contamination of medications.</p> <p>Measures taken or systems altered to ensure the problem does not recur: The Director of Nursing, the facilities Pharmaceutical Consultant and designees will conduct medication administration reviews for licensed nurses to assure comprehension of infection control practices required during medication administration.</p> <p>Plans to monitor performance to ensure solution is sustained: Audits of medication administration reviews will be submitted to the quality Assurance committee for review and recommendation.</p> <p>Title of Person Responsible for Compliance Director of Nursing Services and Administrator</p> <p>Date of compliance: August 1st, 2012</p>	

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F 441	<p>Continued From page 29</p> <p>the tablet into the medication cup, an additional tablet fell onto the top of the medication cart. LN B picked up the tablet with his ungloved hand, and placed it back into the house supply bottle of Vitamin D.</p> <p>LN B was asked if he was aware of the break in infection control. He indicated he was not. He was made aware of the contamination of the house supply vitamin D, by placing the contaminated tablet back into the bottle with the other tablets. LN B stated, "Oh, ok, I see what you mean."</p>	F 441		