STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	614 WEST 14TH STREET MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. It included a Residential State Licensure Survey. Survey dates: January 27, 28, 29 and February 1, 2, 3 and 4, 2016. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census bed type: SNF/NF: 36 Residential: 31 Total: 67 Census payor type: Medicare: 13 Medicaid: 18 Other: 36 Total: 67 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on February 8, 2016.	F 0000	This plan of correction is prepared and executed because the provision of state and federal law require it and not because Marion Rehabilitation and Assisted Living Center agrees with the allegations made in the cited deficiencies. The facility maintains that the deficiencies do not jeopardize the health and safety of guests, nor are they of such character so as to limit our capability to render adequate care. Please consider this plan of correction as our credible statement of compliance. We respectfully request paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0176 SS=D Bldg. 00	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interview and record review, the facility failed to determine the resident was safe for self administration by assessment prior to the resident administering their own medication (Resident #5). Findings include: During an observation of Resident #5's room on 01/28/2016 8:22 a.m., a pharmacy bottle was observed sitting on a table at bedside with a bottle of Systane eye drop solution inside with an expiration date of 12/2015. The resident indicated her doctor had told her she could keep the medication at her bedside to use as needed. The directions on the pharmacy bottle indicated to instill one drop into each eye once per day. Resident #5 indicated that she used the eye drops several times during the day every day as indicated by her doctor. During an observation of Resident #5 on	F 0176	F176 Corrective action for residents affected by the alleged deficient practice: A medication self-administration assessment for Resident 5 was completed on 2-1-16. Identification of other residents affected and corrective action: All residents who self-administer their medications have been reviewed to ensure that a medication self-administration assessment has been completed. (No other residents in the facility self-administer their medications) Systemic changes to ensure that alleged	03/05/2016

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	02/02/2016 at 8:19 a.m., the pharmacy bottle containing Systane eye drop solution was observed sitting on the bedside table. A review of the medical record for resident #5 began on 01/28/2016 9:58 a.m. Diagnosis for the resident included, but were not limited to osteoporosis, major depressive disorder, urinary incontinence, and dry eye syndrome. The most current Minimum Data Set assessment (MDS), dated 12/30/2015, indicated the resident was cognitively intact. There was no care plan indicating Self-Administration for Resident #5. During an interview with LPN #1 on 02/01/2016 at 9:28 a.m., she indicated she was the nurse for the E Hall that day and that there was not a resident who self-administered their medication on that hallway. During an interview with Resident #5 on 02/01/2016 at 9:40 a.m., she again indicated the doctor told her she could have her prescribed eye drops at her bedside. The pharmacy bottle was observed on the bedside table and labeled with the Resident's First and Last name and indicated inside was Systane Balance 0 .6% eye drops, instill one drop per eye every two hours. The lid of the pharmacy		deficient practice does not recur: Nursing staff will be educated on the self-administration of medication assessment policy. Residents who want to self-administer their medications will be assessed at admission and quarterly thereafter. Monitoring of the corrective action: The DON or licensed designee will audit new admissions and /or resident requests for self administration of medications 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure proper and timely assessments. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	

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	bottle came off easily and there was a bottle of Systane Eye Drops in the container. The directions indicated to instill one drop into each eye once per day. The bottle of Systane Ultra had a manufacturer's expiration date of 12/2015. During an interview with LPN #1 on 02/01/2016 at 1:18 p.m., she indicated she knew Resident #5 had eye drops at her bedside but did not know they were expired. LPN #1 indicated there was now a care plan for Resident #5 in regards to self-administration. LPN #1 then went into Resident #5's room, checked the medication bottle and indicated the medication was Systane eye drop solution and that the eye drops were expired and removed them from the room. During an interview with LPN #2 on 02/02/2016 at 9:39 a.m., she indicated she read the physician order for Resident #5, dated 11/13/2015, as only a bottle of Artificial Tears should be kept at the bedside. During an interview with the Director of Nursing (DON) on 02/02/2016 at 9:46 a.m., she indicated that Artificial Tears and Systane are one in the same. The DON indicated that Systane is the type of artificial tears the resident was using.			

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	The DON then indicated that there was not an assessment or care plan for medication self-administration for Resident #5 prior to 2/1/2016. During an interview with Resident #5 on 02/04/2016 at 9:01 a.m., she indicated that she did not follow the directions on the bottle of her eye drops and that she was free to use them as she wanted. The pharmacy bottle containing the Systane eye drop solution was observed on the bedside table of Resident #5. The pharmacy bottle indicated [Resident first and last name] Systane Balance 0.6% with directions indicating to instill one drop per eye every two hours. A review of a physician order sheet for Resident #5, dated 11/13/2015, provided by the Business Office Manager (BOM) on 02/01/2016 at 12:59 p.m. indicated: "1. Artificial Tears as needed during daytime. (may keep at bedside) 2. Systane gel @HS 3. Restasis BID" A review of the Order Review Report for Resident #5 for the month of December, 2015 was provided by the DON on 2/3/2016 at 3:00 p.m. It indicated a physician order for "Systane Balance Solution instill one unit in both eyes			

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	every two hours as needed for dry eyes related to DRY EYE SYNDROME OF UNSPECIFIED LACRIMAL GLAND" with an order date and start date of 11/13/2015. A review of the Medication Administration Record for Resident #5 for the month of December, 2015 began on 02/01/2016 at 1:03 p.m. It indicated "Systane Balance Solution (Propylene Glycol) Instill one unit in both eyes every two hours as needed for DRY EYE SYNDROME OF UNSPECIFIED LACRIMAL GLAND " The medication was ordered as a PRN [as needed] medication and not charted as having been administered by staff. A review of the policy titled "2.1 Self Administering Medications", last reviewed 5/10/10, indicated the following: "...2. Facility, in conjunction with the Interdisciplinary Care Team, should assess and determine, with respect to each resident, whether Self-Administration of medications is safe and appropriate. 3. To ensure safe and appropriate Self-Administration, Facility should educate residents to ensure that a resident is able to:			

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	3.1 state the name, dose, strength, frequency, and purpose for use of his/her medications; 3.2 Understand the possible side effects of his/ her medications and that he/she should notify Facility staff if he/she experiences any such side effects; 3.3 Correctly administer, inject or apply his/her medications; 3.4 Correctly store his/her medications in a locked compartment. 4. Facility should regularly observe the resident Self-Administer medications safely and appropriately.... 5. Facility should ensure that orders for Self-Administration list the specific medication(s) the resident may Self-Administer... 8. If a resident Self-Administers his/her medications, Facility, in conjunction with the Interdisciplinary Care Team, should routinely assess the resident's cognitive, physical and visual ability to carry out this responsibility per Facility policy...." 3.1-12(a)(14)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the			

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	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 §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). Based on observation, interview, and record review, the facility failed to develop individualized careplans for 1 of 1 residents reviewed for urinary tract infection and isolation practices (Resident #36) and 1 of 1 residents reviewed for medication self-administration (Resident #5) 1. On 2/1/16 at 12:46 p.m., Resident #36 was observed sitting in her room. There was a sign on her door indicating isolation precautions were in place. Resident #36 had a current, 11/23/15, quarterly Minimum Data Set (MDS) assessment indicating she was moderately cognitively impaired and was	F 0279	F279 Corrective action for residents affected by the alleged deficient practice: Care plans for residents 36 and 5 have been updated. Identification of other residents affected and corrective action: Residents have the potential to be affected by the alleged deficient practice. Current residents' care plans will be reviewed and updated to reflect their individual needs.	03/05/2016

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	occasionally incontinent of urine. Review of Resident #36's clinical record began on 2/1/16 at 1:25 p.m. A urine culture, dated 1/21/16 and provided by the DON on 2/4/16 at 9:54 a.m., indicated Resident #36 had vancomycin resistant enterococcus (an anti-biotic resistant organism). There was no careplan in the resident's clinical record regarding her urinary tract infection or for isolation practices. During an interview, on 2/2/16 at 10:10 a.m., CNA #37 indicated staff obtained resident's individualized plans of care on the Point of Care application on facility issued iPods. During an interview, on 2/4/16 at 9:42 a.m., the DON and Nurse Consultant indicated there had not been a careplan developed for the resident's urinary tract infection or for isolation practices. 2. During an observation of Resident #5's room on 01/28/2016 8:22 a.m., a pharmacy bottle was observed sitting on a table at bedside with a bottle of Systane eye drop solution inside with a manufacturers expiration date of 12/2015. The resident indicated her doctor had told her she could keep the medication at her bedside to use as needed. The directions on the pharmacy		Systemic changes to ensure that alleged deficient practice does not recur: Licensed nursing staff will be educated on the care plan process. Monitoring of the corrective action: the DON or licensed designee will audit residents, during clinical meeting, with new needs for changes 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure resident's needs are reflected in accordance with the plan of care. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	

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	bottle indicated to instill one drop into each eye once per day. Resident #5 indicated that she used the eye drops several times during the day, every day as indicated by her doctor. During an observation of Resident #5 on 02/02/2016 at 8:19 a.m., the pharmacy bottle containing Systane eye drop solution was observed sitting on the bedside table. A review of the medical record for resident #5 began on 01/28/2016 at 9:58 a.m. It indicated Resident #5's diagnosis included but were not limited to: osteoporosis, major depressive disorder, urinary incontinence, dry eye syndrome. The most current Minimum Data Set assessment (MDS), dated 12/30/2015, indicated the resident was cognitively intact. There was no care plan indicating Self-Administration for Resident #5. During an interview with LPN #1 on 02/01/2016 at 9:28 a.m., she indicated she was the nurse for the E Hall that day and that there was not a resident who self-administered their medication on that hallway. During an interview with the Director of Nursing (DON) on 02/02/2016 at 9:46 a.m., she indicated that there was not an			

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	assessment or careplan for medication self-administration for Resident #5 prior to 2/1/2016. A review of the policy titled 2.1 Self Administering Medications last reviewed 5/10/10 indicated the following: "...2. Facility, in conjunction with the Interdisciplinary Care Team, should assess and determine, with respect to each resident, whether Self-Administration of medications is safe and appropriate." 3.1-35(a)			
F 0282 SS=D Bldg. 00	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. Based on observation, record review and interview, the facility failed to ensure residents with blood pressure monitoring three times a day prior to antihypertensive medication administration received those services as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications, (Resident #14) and followed standards for glucose testing for	F 0282	F282 Corrective action for residents affected by the alleged deficient practice: Resident 14 vital signs are being monitored prior to medication administration of medications with parameters. As soon as the facility received notification	03/05/2016

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	2 of 2 residents observed on "D" hall. (Resident #30 and #110) Findings include: 1. The clinical record of Resident #14 was reviewed on 2/1/16 at 2:35 p.m. Diagnoses included, but were not limited to, pleural effusion, edema, heart failure, chronic obstructive pulmonary disease with acute exacerbation, cardiomegaly, heart disease, atrial fibrillation, diabetes mellitus type II, anxiety disorder and anemia. Record review indicated the physician ordered the following on 12/22/15: "...Cardizem [an antihypertensive medication] tablet...Give 60 mg [milligrams] by mouth three times a day for HTN [hypertension]; CHF [congestive heart failure] Hold if Systolic B/P [blood pressure] > [greater than] 100. A review of the "...Weights and Vitals Summary... " progress notes and medication administration record from 1/1/16 through 1/21/16 provided by the Director of Nursing (DON) on 2/1/16 at 5:20 p.m. indicated the following: a. Resident #14's blood pressure was assessed one time a day on 1/2/16,		from the surveyor regarding the improper glucose monitoring, the nurse was immediately educated on the correct procedure for glucose monitoring. Identification of other residents affected and corrective action: residents who receive glucose monitoring or have medications with parameters have the potential to be affected by the alleged deficient practice. Systemic changes to ensure that alleged deficient practice does not recur: Licensed nursing staff have been educated on the proper procedure for glucose monitoring and administering medication with parameters Monitoring of the corrective action: the DON or licensed designee will audit new physicians orders, during clinical meeting, 5 times per week for 4 weeks, then weekly for 8 weeks, then	

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	1/3/16, 1/4/16, 1/6/16, 1/7/16, 1/8/16, and 1/10/16 through 1/15/16, 1/17/16, 1/19/16, and 1/20/16. b. Resident #14's blood pressure was assessed twice daily on 1/1/16, 1/5/16, 1/9/16, 1/16/16, 1/18/16 and 1/21/16. c. Resident #14's blood pressure was not assessed three times a day prior to Cardizem administration as ordered. During an interview with the Director of Nursing (DON) and the Administrator on 2/2/16 at 9:13 a.m., the DON indicated the supplemental blood pressure monitoring dropped off the electronic medical administration record on January 1, 2016 and did not trigger the nurse to document or assess Resident #14's blood pressure prior to Cardizem medication administration for part of January 2016. The DON further indicated the nurse(s) should have assessed and documented the blood pressure as ordered. A review of a "General Note" provided by the DON on 2/4/16 at 1:05 p.m. and created on 2/4/2016, indicated the following: A review of the policy titled "COVENANT CARE MEDICATION ADMINISTRATION OPERATING		monthly for 3 months. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	

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	STANDARD GUIDELINE.", provided by the Nurse Consultant on 2/2/16 at 9:47 a.m., indicated the following: "...PRACTICE: Medications will be given in a manner which will prevent error related to the prescribing, dispensing and administration, or monitoring of a drug. ...PROCEDURE: ...Check pertinent vital signs such as HR (heart rate) and BP (blood pressure) prior to giving medications with parameters. No further information was provided by exit on 2/4/16. 2. During a medication administration observation, beginning on 2/3/16 at 10:33 a.m., the following was observed: LPN #30 removed two glucose testing strips from the storage vial and placed them in a small plastic medication cup. She then placed the cup on top of the medication cart and opened the top drawer of the cart. Inside the drawer, another small plastic cup contained one glucose testing strip. LPN #30 indicated she had left the strip there following the a.m. medication pass due to not having a vial of strips on her medication cart.			

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	LPN #30 removed the cup containing the strip from the medication cart and placed the cup containing the two strips into the cart. She proceeded to Resident #14's room, carrying a glucometer, gloves, and the test strip. LPN #30 then performed a blood glucose test on Resident #14, using the test strip that had been stored in the plastic medication cup. She then removed her gloves, left the room, and walked to the nurse's station. LPN #30 gathered the glucose meter, one test strip from the plastic cup in the medication cart, and a pair of gloves. She proceeded to Resident #110's room. LPN #30 performed a finger-stick on Resident #110 with a lancet. LPN #30 then performed a blood glucose test on Resident #110, using the test strip that had been stored in the plastic medication cup. LPN #30 indicated she would not have performed the process differently. During an interview, on 2/3/16 at 2:01 p.m., the Nurse Consultant indicated the glucose testing strips should remain stored in the original container. Review of a document, titled " USER'S GUIDE" for the Even Care G2 Blood Glucose Monitoring System, provided by			

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	the Nurse Consultant on 2/3/16 at 2:59 p.m., indicated the following: "...IMPORTANT: Immediately close the vial cap of the test strip bottle tightly after each use. Keep the unused strips in the original bottle. DO NOT leave any test strips outside the bottle while not in use...." 3.1-35(g)(2)			
F 0322 SS=D Bldg. 00	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.			
	Based on observation, interview, and record review, the facility failed to ensure safe practices were followed in the care of a gastric tube for 1 of 1 residents observed with gastric tubes (Resident	F 0322	F322 Corrective action for residents affected by the alleged deficient practice: Corrective action for	03/05/2016

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	#51). Findings include: During a medication administration observation, beginning on 2/3/16 at 11:59 a.m., the following was observed: LPN #30 entered Resident # 51's bathroom and donned gloves. Hand hygiene was not performed. LPN #30 filled 2 plastic cups, one containing a crushed tablet of tramadol 50 mg (pain medication) with water from the sink. LPN #30 carried the items to Resident #51's bedside and placed them on the end table. Resident #51 was in bed, with enteral feeding running into a port on her gastrostomy tube continuously from a pump. LPN #30 drew 40 milliliters of water up into a large piston syringe. She then opened a separate port on Resident #51's gastostomy tube, pushed the water into the port with the syringe, and closed the port. LPN #30 then drew up the water containing the tramadol tablet, opened the port, pushed the water into the port with the syringe, and closed the port. She then drew up 30 milliliters of water from a cup, pushed the water into port with the syringe, and closed the port. The enteral feeding continued to run into the gastrostomy tube from the pump.		resident 51 cannot be accomplished as it occurred in the past. . As soon as the facility received notification from the surveyor regarding the improper medication administration for a g-tube, the nurse was immediately educated on the correct procedure for g-tube medication administration. Identification of other residents affected and corrective action: residents who receive medications thru g-tubes have the potential to be affected by the alleged deficient practice. Systemic changes to ensure that alleged deficient practice does not recur: Licensed nursing staff have been educated on proper g-tube care and medication administration. Monitoring of the corrective action: the DON or licensed designee will observe medication administration via g-tube by licensed nurses, 3 times per week	

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	LPN #30 indicated she stopped the tube feeding at times and used that port, and other times, she used the alternate port. She further indicated she pushed the fluids into the tube with the syringe because they went in easily. During an interview, in 2/3/16 at 2:01 p.m., the DON and Nurse Consultant indicated the fluids should not be pushed in with a syringe. Review of a policy, titled " COVENANT CARE MEDICATION ADMINISTRATION OPERATING STANDARD GUIDELINE", dated 12/2012 and received from the DON on 2/3/16 at 2:30 p.m., indicated the following: "...Enteral feedings-...Wash hands and don gloves...Check for placement and tube patency...Do not add medication directly to an enteral feeding formula...Prior to administering med, stop the feeding and flush the tube with a minimum of 15mL water...Administer medications...Resume feeding as ordered...." 3.1-44(a)(2)		for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure proper procedure is followed per policy. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	
F 0323 SS=D	483.25(h) FREE OF ACCIDENT			

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Bldg. 00	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. Based on observation, interview, and record review, the facility failed to ensure medications were stored securely for 1 of 30 residents reviewed for room safety (Resident #5). This practice had the potential to affect 1 resident with wandering behavior of 14 residents residing on the "E" Hall. Furthermore, the facility failed to ensure sharps devices were disposed of properly for 2 of 2 residents observed for glucose monitoring (Residents #14 and #110). 1. During a medication administration observation, beginning on 2/3/16 at 10:33 a.m., the following was observed: LPN #30 performed a finger-stick on Resident #14 with a lancet and tested the resident's blood glucose. LPN #14 discarded the lancet in the trash can next to Resident #14's bed. LPN #30 then returned to the medication cart. At 10:39 a.m., LPN #30 proceeded to Resident #110's room. LPN #30 performed a finger-stick on Resident #110 with a lancet. LPN #30 discarded the lancet in the trash can next to	F 0323	F323 Corrective action for residents affected by the alleged deficient practice: Corrective action for residents 14 and 110 cannot be accomplished as it occurred in the past. Resident 5's expired medication was immediately removed from the resident's room. Identification of other residents affected and corrective action: residents who receive glucose monitoring or have medications at bedside have the potential to be affected by the alleged deficient practice. Systemic changes to ensure that alleged deficient practice does not recur: Nursing staff have been educated on disposal of sharps and securing medications of residents	03/05/2016

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	Resident #110's bed and tested the resident's blood glucose. LPN #30 indicated she would not have performed anything differently. Review of a policy, titled "COVENANT CARE MEDICATION ADMINISTRATION OPERATING STANDARD GUIDELINE", dated 12/2012 and provided by the DON on 2/3/16 at 2:30 p.m., indicated the following: "...Blood Glucose Monitoring-...Properly dispose of supplies...." Review of a document, titled "RECOMMENDED INFECTION CONTROL PRACTICES TO PREVENT PATIENT-TO-PATIENT TRANSMISSION OF BLOODBORNE PATHOGENS", published by the Centers for Disease Control and Prevention, and provided by the Administrator on 2/3/16 at 4:13 p.m., indicated the following: "Dispose of used fingerstick devices and lancets at the point of use in an approved sharps container...." 2. During an observation of Resident #5's room on 01/28/2016 8:22 a.m., a pharmacy bottle was observed sitting on a table at bedside with a bottle of Systane eye drop solution inside with an expiration date of 12/2015. The resident indicated her doctor had told her she		who self-administer. Resident who self-administer medications will be educated on securing their medication. Monitoring of the corrective action: the DON or licensed designee will audit resident's room who self administer medications, 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure medications are secured as required as well as check expiration dates of such medications. The DON or licensed designee will observe glucose testing, 5 times per week for 4 weeks, the weekly for 8 weeks, then monthly for 3 months to ensure proper disposal of lancets. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	

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	could keep the medication at her bedside to use as needed. The directions on the pharmacy bottle indicated to instill one drop into each eye once per day. Resident #5 indicated that she used the eye drops several times during the day every day as indicated by her doctor. During an observation of Resident #5 on 02/02/2016 at 8:19 a.m., the pharmacy bottle containing Systane eye drop solution was observed sitting on the bedside table. A review of the medical record for Resident #5 began on 01/28/2016 at 9:58 a.m.. The resident's diagnosis included, but were not limited to osteoporosis, major depressive disorder, urinary incontinence, dry eye syndrome. The most current Minimum Data Set assessment (MDS), dated 12/30/2015, indicated the resident was cognitively intact. During an interview with Resident #5 on 02/01/2016 at 9:40 a.m., she again indicated the doctor told her she could have her prescribed eye drops at her bedside. The pharmacy bottle was observed on the bedside table and labeled with the Resident's First and Last name and indicated inside was Systane eye drop solution. The directions indicated to			

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	instill one drop per eye every two hours. The lid of the pharmacy bottle came off easily and there was a bottle of Systane Eye Drops. A review of a physician order sheet for Resident #5, dated 11/13/2015 provided by the Business Office Manager (BOM) on 02/01/2016 at 12:59 p.m., indicated: 1. Artificial Tears as needed during daytime. (may keep at bedside) 2. Systane gel @HS 3. Restasis BID A review of the policy titled 5.3 storage and expiration of medications, biologicals, syringes and needles, last revised 1/1/03, provided by the nurse consultant on 2/2/2016 at 10:47 a.m., indicated the following: "...4. Facility should ensure that medications and biologicals: 4.2 have not been retained longer than recommended by manufacturer or supplier guidelines 13. Bedside Medication Storage: 13.1 facility should not administer/provide bedside medications or biologicals without a physician/ prescriber order and approval by the interdisciplinary care team and facility administration. 13.2 Facility should store bedside			

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	medications or biologicals in a locked compartment within the resident's room...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0431 SS=D Bldg. 00	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 controls, and permit only authorized personnel to have access to the keys. 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			

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	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. Based on observation, interview, and record review, the facility failed to ensure medication carts were free of loose pills and expired medications for 1 of 3 medication carts observed during medication storage (North "E" Hall cart). This practice had the potential to affect 11 residents whose medications were stored in the north cart of 14 residents residing on the "E" Hall. Furthermore, the facility failed to ensure medications were stored securely for residents who self-administered medications (Resident #5). This practice had the potential to affect 1 resident with wandering behavior of 14 residents residing on the "E" Hall. Findings include: 1. During medication storage observation, beginning on 2/2/16 at 9:22 a.m., RN #33 unlocked the north "E" hall cart for observation. A vial of Novolog insulin was observed in the top drawer of the cart, labeled with Resident #6's name and a discard date of 1/29/16. During observation of the remaining drawers, the medication cart was found to contain 3 loose pills throughout the cart. RN #33 indicated the insulin and pills should have been disposed of.	F 0431	F431 Corrective action for residents affected by the alleged deficient practice: The expired insulin and loose pills were immediately destroyed. Resident 5's expired eye drops were removed from the resident's room. A locked box has been provided to the resident for storage of her medication. Identification of other residents affected and corrective action: residents have the potential to be affected by the alleged deficient practice. The medication carts have been inspected for loose pills and expired medications which were then destroyed. Systemic changes to ensure that alleged deficient practice does not recur: Licensed nursing staff have been educated on medication storage and disposal of expired medications. Monitoring of the corrective action: The DON or licensed designee will audit the med carts 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 8 weeks, then monthly for 3 months to ensure expiration dates are within guidelines. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	03/05/2016

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	Review of Resident #6's clinical record began on 2/2/16 at 10:30 a.m. Resident #6 had current physician's orders for Novolog insulin per sliding scale four times daily. Review of Resident #6's medication administration records for January and February, 2016 indicated Resident #6 had received Novolog insulin on 1/30/16, 1/31/16, 2/1/16, and 2/2/16. 2. During an observation of Resident #5's room on 01/28/2016 8:22 a.m., a pharmacy bottle was observed sitting on a table at bedside with a bottle of Systane eye drop solution inside with an expiration date of 12/2015. The resident indicated her doctor had told her she could keep the medication at her bedside to use as needed. The directions on the pharmacy bottle indicated to instill one drop into each eye once per day. Resident #5 indicated that she used the eye drops several times during the day every day as indicated by her doctor. During an observation of Resident #5 on 02/02/2016 at 8:19 a.m., the pharmacy bottle containing Systane eye drop solution was observed sitting on the bedside table.			

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	During an interview with LPN #1 on 02/01/2016 at 1:18 p.m., she indicated she knew Resident #5 had eye drops at her bedside but did not know they were expired. LPN #1 then went into Resident #5's room, checked the medication bottle and indicated the medication was Systane eye drop solution and that the eye drops were expired and removed them from the room. Review of a policy, titled "...Storage and Expiration of Medications...", dated 1/1/13, and provided by the Nurse Consultant on 2/2/16 at 10:47 a.m., indicated the following: "...2. The facility should ensure that medications...are stored in an orderly manner... 4.2. Have not been retained longer than recommended... 13. Bedside Medication Storage: 13.1 facility should not administer/provide bedside medications or biologicals without a physician/ prescriber order and approval by the interdisciplinary care team and facility administration. 13.2 Facility should store bedside			

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	medications or biologicals in a locked compartment within the resident's room...." 3.1-25(m)			
F 0441 SS=D Bldg. 00	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			

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	for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were followed, in regard to clean linen handling, Mantoux tuberculin test results being read for 1 of 6 reviewed for immunizations (Resident #110), isolation personal protective equipment precautions not followed by facility staff for 1 of 1 resident in isolation for Vancomycin - Resistant Enterococci (VRE) (Resident #36) (Activity Aide #34), sanitization of glucometer and handwashing. (Resident #30 and #110). This deficiency had the potential to affect 31 of 31 residents residing in the facility. Findings include: 1. During an observation of clean linen handling on D hall by laundry aide #3 on 1/28/16 the following was observed: a. At 9:25 a.m., laundry aide #31 removed clean linen from the laundry cart and held a pile of clean linen with one hand on top and one on the bottom of the pile. The clean linen was held against	F 0441	F441 Corrective action for residents affected by the alleged deficient practice: resident 110's PPD documentation cannot be corrected as it occurred in the past. When linen handling and PPE usage issues were brought to the facility's attention by the surveyor, the indicated employees were educated on proper linen and PPE usage procedure.Identification of other residents affected and corrective action: current residents have the potential to be affected by the alleged deficient practice. Systemic changes to ensure that alleged deficient practice does not recur:Nursing staff have been educated on PPD administration/documentation procedure. The laundry staff have been educated on linen handling procedure. The activity staff have been educated on PPE usage procedure. Monitoring of the corrective action: the DON or licensed designee will observe handwashing on 3 employees, 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure proper handwashing procedure during care. The DON or licensed designee is will review new	03/05/2016

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	her body from her chest to right below her chin as she delivered the clean laundry to room D130. b. At 9:29 a.m., laundry aide #31 removed clean linen from the laundry cart and held a pile of folded clean linen with one hand on top and one on the bottom of the pile. The clean linen was held against her torso as she delivered the clean laundry to room D136. During an interview with laundry aide #31 and the Director of Environmental Services on 2/3/16 at 2:13 p.m., laundry aide #31 indicated laundry was to be held away from the body and held only with the hands. Laundry aide #31 further indicated she thought she could carry clean linens against her body but not dirty linens. The Director of Environmental Services indicated laundry aide #31 would touch the clean linen against her body when she would try to put them away in the residents' closets, because she was short. He further indicated she had no problem putting linen in the linen closets on the hall. During an interview with the Administrator on 2/3/16 at 2:35 p.m., she indicated clean linen was to be held away		admission PPD process, 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure PPD administration and documentation. The DON or licensed designee will observe PPE usage for any resident in isolation, 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure proper PPE usage. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	

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	155799	A. BUILDING 00 B. WING	02/04/2016

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	from the staff's body when handled. 2. The clinical record of Resident #110 was reviewed on 2/3/16 at 10:09 a.m. Diagnoses included, but were not limited to, end stage renal disease, pneumonia, elevated white blood count, hypertension and dependence on renal dialysis. The clinical record indicated Resident #110 was admitted on 11/2/15 from a hospital. Record review indicated on 11/2/15, a physician order for the following: "...May have 2 Step Mantoux PPD [purified protein derivative] [a skin test to determine tuberculosis] on Admission every day shift for 1 Administrations until finished READ PPD 48 Hrs, [hours] after administration - Step 1. Document details on resident's Immunization record...." A review of the November, 2015 "Medication Administration Record" (MAR) indicated no result was recorded on the MAR from 11/2/15 through 11/6/15. During an interview with the Director of Staff Development on 2/2/16 at 10:38 a.m., she indicated Resident #110 had the PPD Step 1 at the hospital on 11/2/15 and it should have been read on 11/4/15 at the facility. She indicated it was not read.			

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	During an interview with the Director of Staff Development on 2/2/16 at 11:16 a.m., she indicated since October 2015, she had been scheduling the PPD for day shift to be administered and to be read on two days later on the evening shift to ensure the window of 48 hours was met. She further indicated if one person misses a step then the facility would need to start with the Stage 1 PPD. A review of policy titled "TUBERCULOSIS CONTROL PLAN" provided by the Nurse Consultant on 2/2/16 at 12:57 p.m. indicated the following: "...PURPOSE: To minimize employee exposure to, and subsequent infection with, tuberculosis (TB). POLICY: This facility has adopted and will enforce the latest recommendations of the Centers for Disease Control and Prevention (CDC) regarding prevention of occupational transmission of TB among its employees and residents. The following procedures reflect the most recent CDC guidelines published in 2005... ...PROCEDURE: ...C. ADMISSIONS 1. All residents will be screened on admission for infection with tubercle			

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	bacilli on admission. During an interview with the Nurse Consultant on 2/2/16 at 1:15 p.m., she indicated the policy related to "TUBERCULOSIS CONTROL PLAN" indicated no time frame for reading a PPD, but should be read between 48-72 hours after administration. No further information was provided by exit on 2/4/16. 3. On 2/1/16 at 12:46 p.m., Activity Assistant #34 was observed leaving Resident 36's room. She then removed a red biological bag from a cart placed outside of the room and re-entered the resident's room. At 12:47 p.m., she again left the room, closing the door behind her. On the door was a sign indicating the resident was in isolation. Activity Assistant #34 proceeded to start pushing a cart of books down the hallway. When asked by the surveyor if she had entered Resident #36's room without personal protective equipment, Activity Assistant #34 indicated she had removed her gown and gloves in the resident's restroom when she had initially exited the room, but had noticed the biohazard bag needed to be changed. She further indicated she had washed her hands, left the room to get a new bag, and had re-entered the room and changed the biohazard bag.			

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	She indicated she had not reapplied a gown or gloves, nor had she re-washed her hands. Review of a urine culture, dated 1/21/16 and provided by the DON on 2/4/16 at 9:54 a.m., indicated Resident #36 had vancomycin resistant enterococcus (an anti-biotic resistant organism). Resident #36 had a current, 11/23/15, quarterly Minimum Data Set (MDS) assessment indicating she was moderately cognitively impaired and was occasionally incontinent of urine. During an interview, on 2/4/16 at 9:42 a.m., the DON and nurse consultant indicated the resident was in isolation due to her urinary infection per CDC recommendations. Review of a policy, titled " Contact Precautions", dated 2012, and provided by the Admissions Director on 2/1/16 at 2:53 p.m., indicated the following: "II. GLOVES AND HAND HYGIENE...B. Gloves should be worn when entering the room...E. After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items...III.GOWNS...A. A gown should be donned prior to entering the room...C. After removal of the gown,			

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	clothing should not contact potentially contaminated environmental surfaces...." 4. During a medication administration observation, beginning on 2/3/16 at 10:33 a.m., the following was observed: LPN #30 applied gloves, without performing hand hygiene, and performed a finger-stick on Resident #14 with a lancet. LPN #14 discarded the lancet in the trash can next to Resident #14's bed. LPN #30 then performed a blood glucose test on Resident #14. She then removed her gloves, left the room, and walked to the nurse's station. LPN #30 then answered the phone at the nurse's station. After completing the phone call, LPN #30 then approached the nurse's station sink and washed her hands. LPN #30 then donned another pair of gloves, cleaned the glucometer with a disposable wipe, and removed the gloves. She did not perform hand hygiene after removing the gloves. LPN #30 gathered the glucose meter and testing supplies. She proceeded to Resident #110's room. LPN #30 applied gloves, without performing hand hygiene, and performed a finger-stick on Resident #110 with a lancet. LPN #30 discarded the lancet in the trash can next to Resident #110's bed. LPN #30 then performed a blood glucose test on Resident #110.			

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	LPN #30 then carried the glucometer to the medication cart and while wearing the same pair of gloves, cleaned the glucometer with a disposable wipe. She placed the glucometer on a paper towel and then removed the gloves. LPN #30 indicated she would not have performed the process differently. Review of a policy, titled "COVENANT CARE MEDICATION ADMINISTRATION OPERATING STANDARD GUIDELINE", dated 2/2012 and provided by the DON on 2/3/16 at 2:30 p.m., indicated the following: "...Blood Glucose Monitoring-...Wash hands and don gloves...." Review of a document, titled "RECOMMENDED INFECTION CONTROL PRACTICES TO PREVENT PATIENT-TO-PATIENT TRANSMISSION OF BLOODBORNE PATHOGENS", published by the Centers for Disease Control and Prevention, and provided by the Administrator on 2/3/16 at 4:13 p.m., indicated the following: "Dispose of used fingerstick devices and lancets at the point of use in an approved sharps container...."			

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	3.1-18(b) 3.1-18(e) 3.1-18(l)			
F 0502 SS=D Bldg. 00	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to ensure labs were completed for 1 of 5 residents reviewed for lab results. (Resident #51) Findings include: The clinical record for Resident #51 was reviewed on 2/1/16 at 10:30 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus type II, metabolic encephalopathy, hypertension, hyperosmolality and hypernatremia, lymphocyte depleted classical Hodgkin lymphoma and cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery. A review of Resident #51's current physician orders indicated, the resident had orders that included, " ...Lab - CMP	F 0502	F502 Corrective action for residents affected by the alleged deficient practice: Resident 51's labs were drawn on 2-2.16 Identification of other residents affected and corrective action: residents with lab orders have the potential to be affected by the alleged deficient practice. Systemic changes to ensure that alleged deficient practice does not recur: current residents' charts will be audited to ensure that labs have been drawn as ordered. The	03/05/2016

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	[comprehensive metabolic panel] every 3 months due JAN [January], APRIL, JULY, OCT every night shift every 90 day(s)... Order Date of 07/01/2015...Start Date of 07/29/2015...." "...Lab - HGB A1C [hemoglobin A1C] [a lab test used to test how well diabetes was controlled] every 3 months due OCT [October] every night shift every 90 day(s)...Order Date 07/01/2015...Start Date...10/14/2015. A review of the labs completed July, 2015 through January, 2016 for Resident #51 indicated no lab results for a CMP or HGB A1c. During an interview with the Director of Nursing (DON) on 2/1/16 at 1:20 p.m., she indicated the labs CMP and HGB A1c for Resident #51 were not completed. The DON indicated she was unaware Resident #51 had uncompleted labs for July, 2015 through January, 2016. She indicated labs were not completed as ordered due to staff turnover and were not monitored as closely with the new staff. The DON further indicated the Nurse Practitioner was notified and a new order was received for the labs to be drawn on 2/2/16.		licensed nursing staff have been re-educated on the lab testing process. Monitoring of the corrective action: the DON or licensed designee will conduct a lab audit, 5 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months to ensure labs are obtained per MD order. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consistent pattern of compliance is achieved.	

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	A review of a "Physician's Order Note" provided DON on 2/3/16 at 2:30 p.m. and created on 2/3/2016, indicated the following: "...Late Entry for 2/1/2016 at 1340 [1:40 p.m.]...NP [Nurse Practitioner] updated on missed HGB A1C and CMP. New order to be drawn 2/2/16 then every 3 months thereafter...." During an interview with the Director of Nursing, Nurse Consultant and the Administrator on 2/4/16 at 10:15 a.m., the DON indicated there was no system in place to track labs for long term residents prior to 2/1/16. The Nurse Consultant indicated there was no policy for following physician orders or labs. She indicated it was a standard of care. No further information was provided by exit on 2/4/16. 3.1-49(a)			