

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

AMENDED

PRINTED: 11/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2011
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NAME OF PROVIDER OR SUPPLIER CAMELOT MANOR NURSING CARE FAC	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET ST GRANITE FALLS, NC 28630
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>No deficiencies cited as a result of complaint investigation survey event id: HGSM11.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the</p>	F 225	<p>Any alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property will be reported immediately to the Administrator and/or Assistant Administrator and to other officials in accordance with State Law; including the State survey and certification agency and if the alleged violation is verified, appropriate corrective action is taken.</p> <p>The Director of Nursing or her designee will review any allegations of abuse via the daily incident report review system and complaint reports (verbal or written) in the morning meetings. Any allegations will be reported to the proper agencies via the approved 24-hour report form. After investigation, the findings will be documented on the five day report and either faxed or mailed to the proper agencies.</p> <p>In the event that an incident occurs during times when the Director of Nursing and the Assistant Director of Nursing are not present in the facility, the facility Charge Nurse will be able to report occurrence to the Director of Nursing via telephone and receive instructions on how to proceed.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Samp B. E. Hard</i>	TITLE <i>RS</i>	(X6) DATE <i>11/11/11</i>
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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.

Original Signature Date: 11-4-11

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BY: *ORW*

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F 225	<p>Continued From page 1</p> <p>incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of facility abuse investigations the facility failed to report an allegation of abuse to the North Carolina Health Care Personnel Registry with a twenty-four (24) hour and a five (5) day report for one of three investigations reviewed.</p> <p>The findings are:</p> <p>Review of an abuse investigation dated 2/11/11 indicated a resident reported that a nursing assistant was rude to her and jerked her out of her chair. An investigation was done, a result summary dated 02/13/11 stated: 1. No evidence of abuse after interview with staff and resident. 2. Recommend MD review for psych consult to assist her end stage dementia and hallucinations. 3. CNA education. This investigation was signed by the previous Director of Nursing. The twenty four (24) hour report as well as the five (5) day report was not sent to the North Carolina Healthcare Personnel Registry.</p> <p>An interview was conducted on 10/12/11 at 3:50 PM with the Director of nursing (DON). She confirmed that the twenty-four (24) hour and the five (5) day reports were not sent to the North Carolina Healthcare Personnel Registry. She reported that a twenty-four (24) and five (5) day report should always be sent regardless of the outcome of the investigation. She further reported</p>	F 225	<p>The Director of Nursing will review all allegations, complaints and incidents in the daily morning meeting. The Administrator and/or Assistant Administrator will review reports following investigation and on a monthly basis. The reports will also be reviewed in the quarterly QAA meeting to assess for procedural variations in reporting occurrences and follow-up investigations.</p> <p>A mandatory in-service for all facility staff is given each year, the most recent being 10/26/2011.</p> <p>Facility staff that could be designated to report, intervene and investigate has reviewed the abuse policy and have verbalized proper procedural components of the investigative and reporting stages. This includes the Director of Nursing, Assistant Director of Nursing, Facility Administrator, Assistant Administrator and the Charge Nurses.</p> <p>Date of Corrective action complete</p>	11/2/2011	

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F 225	Continued From page 2 that staffing records indicated that the nursing assistant accused in the allegation did not come to work on 2/12/11 or 2/13/11.	F 225			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272			

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F 272	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to assess one (1) of three (3) residents observed for incontinence. (Resident # 45). The findings are: Resident # 45 was admitted to the facility with diagnoses which included hypertension, benign prostatic hypertrophy without urinary obstruction and Alzheimer's disease. Current physician's orders included Lasix 60 (sixty) milligrams (mg) daily and Flomax 0.4mg daily. The most recent Minimum Data Set (MDS) was a quarterly assessment dated 09/14/11. Resident # 45 was assessed as having impaired short term and long term memory and severe cognitive impairment. He was also assessed as requiring extensive assistance of two (2) staff with toileting and transfers and as always incontinent of bladder and frequently incontinent of bowel. The previous MDS was a quarterly assessment dated 06/21/11 which assessed him as having impaired short term and long term memory and moderate cognitive impairment. He was also assessed as requiring extensive assistance of two (2) staff with toileting and transfers and as always continent of bladder and bowel. Further review of the medical record revealed that no additional assessment	F 272	To address the cited deficiency for assessment of resident #45 for incontinence, the quarterly continence assessment has been added on all residents as of 10/13/2011. A full assessment was completed on resident #45 on 10/13/2011. As a result of this assessment resident was noted to have a significant change in continence status. A toileting program was initiated and was placed on a restorative nursing program for toileting, transfers, active range of motion for upper extremities and passive range of motion for lower extremities. An initial admission assessment for continence has been added to our admission assessments entitled "Bladder and Bowel Continence Assessment" Staff Nurses will be responsible for its completion. Charge Nurses will review for completion within 24 hrs of resident admission. Charge Nurse will report to Director of Nursing findings of completion of the assessment within 48 hours of admission.		

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F 272	<p>Continued From page 4</p> <p>was completed to evaluate the cause for significant decline in the resident's continence status.</p> <p>A review of the current Care Plan for Resident # 45 revealed the following problem statement: "High risk for skin breakdown due to impaired mobility and Incontinence." The Interventions listed did not identify any specific interventions to address incontinence.</p> <p>Continuous observation of Resident # 45 from on 10/10/11 from 12:18 PM until 1:05 PM revealed he was sitting in the facility's main dining room feeding himself lunch. When he exited the dining room at 1:05 PM a puddle of yellow liquid was observed in front of the table where his wheelchair had been sitting.</p> <p>Observation of Nursing Assistant (NA) # 2 providing incontinence care to Resident # 45 on 10/10/11 at 1:08 PM revealed the incontinence brief was saturated with urine and came apart while being removed from the resident. The fleece pants he was wearing were wet across the back and midway down the back of both legs. The vinyl cushion in the wheelchair was also visibly wet.</p> <p>Observation of NA # 1 toileting Resident # 45 on 10/12/11 at 8:25 AM revealed his incontinent brief was dry when he was placed on the commode. NA # 1 placed the call bell in his hand and told him to ring when he was finished. He rang within five (5) minutes and was assisted back into his wheelchair.</p> <p>Additional observations of Resident # 45 on</p>	F 272	<p>Meeting will be held on a weekly basis with Care Plan nurses to review completion, accuracy and proper interventions of each resident assessed.</p> <p>A report of these reviews and outcomes assessed on usage of this assessment will be reported to the QAA Committee on a quarterly basis.</p> <p>Education on how to complete the new continence assessment form was given to all nurses on 10/19/2011 and 11/1/2011.</p> <p>An in-service for all Medication Aides and C.N.A.'s was completed on 11/2/2011 on continence care and how to report and document changes in patterns and or functionality of the residents.</p> <p>Review completed with Care Plan Nurses on the importance of significant change of status re-evaluation conducted on 10/13/2011 and 11/1/2011.</p> <p>New admission continence assessment initiated on 11/1/2011 for all new residents admitted to the facility. Assessments are made available on the Electronic Medical Record under Admission Assessments.</p> <p>Date of corrective action complete</p>	11/9/2011

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F 272	<p>Continued From page 5</p> <p>10/11/11 at 8:48 AM and 11:14 AM, on 10/12/11 at 11:36 AM and on 10/13/11 at 8:10 AM revealed he had no odor of urine or other signs of incontinence.</p> <p>Interview with NA # 1 on 10/10/11 at 1:16 PM, revealed she tolleted Resident # 45 before lunch between 11:00 AM & 12:00 PM but she was unable to recall exactly what time.</p> <p>In an interview on 10/12/11 at 8:25 AM, NA # 1 stated Resident # 45 had a decline in his condition several months ago with an increase in confusion and incontinence. She stated he has recently shown some improvement and is usually continent of bowel. She further stated: "we try to check him more than every two hours because he voids a lot."</p> <p>In an interview on 10/12/11 at 11:29 AM, NA # 2 stated Resdient # 45 has had a decline over the past six (6) months and is always incontinent of urine but most of the time is continent of bowel. She stated he asks to be taken to the toilet first thing in the morning.</p> <p>In an interview on 10/13/11 at 1:57 PM with the Resident Assessment Nurse in regard to the coding of Resident # 45's continence status on the MDS, she stated she obtains information on continence status from the "Smart Charting" system used by the NA's. Review of documentation by the NA's for the observation period from 9/8 - 9/14/11 revealed documentation of the number of incontinence episodes per shift but didn't document specific times. The MDS nurse was unable to provide documentation that an assessment was completed to evaluate for a</p>	F 272			

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F 272	Continued From page 6 pattern or cause for the change from always continent of bladder on the 06/21/11 quarterly MDS to always incontinent of bladder on the 09/14/11 quarterly MDS. In an interview on 10/13/11 at 2:23 PM, the Director of Nursing (DON) stated Resident # 45 has had a significant overall decline mentally, functionally & physically and had a decline in transfer status and in independence with toileting. She also stated he has been showing some improvement & has been able to tell staff when he needs to void. The DON stated he wasn't put on a continence program & he wasn't assessed by the Nurse Practitioner who was overseeing the facility's continence program. In an interview on 10/13/11 at 2:52 PM with the DON about her expectations for adjustment to a resident's plan of care whenever there is a significant decline in the continence status: she stated she would expect for a complete new assessment to be completed and it should include an evaluation of whether the resident had the potential to be retrained or if the resident needed a scheduled toileting program based on input from the NA's on his voiding pattern. She also stated she would also expect the change to be reflected in the written plan of care including the "Care Tracker" system used by the NA's.	F 272			
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	F 309	To address the cited deficiency concerning residents restraint and or positioning devices removal at meal times and supervised activity a review was conducted on all residents that are in a positioning device or restraint.		

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F 309	<p>Continued From page 7 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility staff failed to remove a soft laptop cushion (Adjustable Positioning System (APS) cushion/lap buddy) during meals for one (1) of two (2) residents observed. (Resident # 99).</p> <p>The findings are:</p> <p>Resident # 99 was admitted to the facility with diagnoses including a stroke, Alzheimer's dementia, and muscle weakness.</p> <p>The admission Minimum Data Set (MDS) dated 08/08/11 indicated severe impairment in short and long term memory and severe impairment in cognition for daily decision making. The resident required limited assistance from staff for activities of daily living.</p> <p>A review of a physician's order dated 10/10/11 stated Adjustable Positioning System (APS) cushion to wheelchair while out of bed to facilitate safe movement through out facility. Remove every two (2) hours, at meal time and during periods of supervised activities.</p> <p>A review of a care plan dated 07/24/11 stated high risk for falls due to confusion, decreased mobility and a history of falls. Interventions were listed in part for lap buddy while in wheelchair.</p>	F 309	<p>Review of all orders and consents was conducted and completed by 11/1/2011.</p> <p>The following corrective action has been implemented for all those residents having potential to be affected by the same deficient practice.</p> <p>Nursing Care worksheets have been revised to reflect all residents who have a restraint or positioning device. Nursing Care worksheets are a communication tool that is updated by the Care Plan Dept, to assist nursing staff to execute current plan of care.</p> <p>Staff assigned to supervise dining areas and activities will be responsible for removal of restraints according to the physician order and plan of care:</p> <ul style="list-style-type: none"> The Charge Nurse will observe all dining areas at each meal to assure proper removal of restraints according to the physician order and plan of care. The staff responsible for conducting supervised activities will complete the Supervised Activities Form and submit completed form to the Charge Nurse daily. <p>The Charge Nurse will document compliance of restraint removal daily qd x 4 weeks on the 24 hr Charge Nurse Report. The Charge Nurse will report results weekly x 4 weeks in the interdisciplinary morning meeting; then report monthly in the interdisciplinary morning meeting.</p>	

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F 309	<p>Continued From page 8</p> <p>A review of a Nurse Aide (NA) Care Plan Report dated 10/13/11 stated wheelchair with (APS) cushion. There was no documentation on the report to remove the cushion every two (2) hours or at meal time or during supervised activities.</p> <p>On 10/10/11 at 1:02 PM Resident # 99 was observed sitting in the hallway in her wheelchair pulling on the side of an (APS) cushion/lap buddy that was attached to the arms of the wheelchair but did not remove it from her wheelchair.</p> <p>On 10/10/11 at 5:54 PM Resident # 99 was observed sitting in her wheelchair in the small dining room with the (APS) cushion/lap buddy positioned on her lap and attached to the arms of her wheelchair. Facility staff was observed sitting across the table from Resident # 99 feeding another resident.</p> <p>On 10/11/11 at 8:58 AM Resident # 99 was observed sitting in her wheelchair in her room eating breakfast. She had a (APS) cushion/lap buddy in her lap and it was attached to the arms of her wheelchair.</p> <p>On 10/12/11 at 5:52 PM Resident # 99 was observed sitting in a wheelchair in the small dining room with her plate on the table in front of her. She had a (APS) cushion/lap buddy in her lap and it was attached to the arms of her wheelchair. Facility staff was sitting at adjacent tables feeding other residents during the observation.</p> <p>During an interview on 10/13/11 at 9:55 AM with Nursing Assistant (NA) # 3 he stated Resident # 99 was capable of removing the lap buddy and</p>	F 309	<p>Director of Nursing will review results of daily observation and restraint removal at meal times and during supervised activities via the 24 hr Charge Nurse Report on a daily basis. Results will be reviewed monthly in the Restraint/Falls Meeting.</p> <p>Monthly reports will be compiled quarterly and presented to the QAA Committee. Monitoring will be ongoing until results show sustained compliance for removal of restraint or positioning devices at supervised meal times and supervised activities.</p> <p>Staff in-services held on 11/2/2011 and 11/9/2011.</p> <p>Date of corrective action complete</p>	11/9/2011	

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F 309	<p>Continued From page 9 frequently took it off.</p> <p>During an interview on 10/13/11 at 1:41 PM with Licensed Nurse (LN) # 1 she verified Resident # 99 had an (APS) cushion ordered by her physician. She stated the facility staff also referred to the (APS) cushion as a lap buddy. She stated Resident # 99 could remove the lap buddy by herself and frequently took it off.</p> <p>During an interview on 10/13/11 at 2:24 PM with NA # 6 she stated Resident # 99 wore her lap buddy all the time except when she ate her meals and "we have to take it off when she eats."</p> <p>During an Interview on 10/13/11 at 2:29 PM with LN # 2 she verified Resident # 99 had a physician order for a (APS) cushion to be removed during meal time and stated the Nursing Assistants have a Care Plan report that served as a worksheet for them to provide daily care to residents. She verified the Nurse Aide Care Plan report did not specifically state to remove the (APS) cushion/lap buddy during meal time but it was common knowledge in the facility to remove them during meal time and Nurse Aides were expected to remove them.</p> <p>During an Interview on 10/13/11 at 3:09 PM with the Director of Nurses (DON) she stated when Resident # 99 was admitted to the facility she was assessed for restraints. She explained the resident would lean forward in her wheelchair and they put the (APS) cushion/lap buddy on her to prevent her from leaning forward and falling out of her wheelchair. She stated it was her expectation staff should not leave the resident in the (APS) cushion/lap buddy all of the time and it should be</p>	F 309		

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F 309	Continued From page 10 removed during toileting, during supervised activities and at every meal. She verified the Nurse Aide Care Plan report did not specify when to remove the (APS) cushion/lap buddy but the Nurse Aides knew they were supposed to remove it during meal time and she expected for them to do so.	F 309		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to ensure fingernails were cleaned and facial hair was removed for two (2) of five (5) dependent sampled residents (Resident #39 and #36).</p> <p>The findings are:</p> <p>1. Resident #39 was admitted to the facility with diagnoses of failure to thrive and dementia, among others. The latest Minimum Data Set, dated 09/19/11, revealed the resident had severe cognitive impairment and required extensive assistance with most activities of daily living. A review of her care plan, revised in September 2011, revealed that the resident required staff assistance with activities of daily living.</p> <p>On 10/10/11 at 12:30 PM, Resident #39 was</p>	F 312	<p>To address the cited deficiency, Resident #39 had a shower with nail care completed on October 12, 2011. Resident has been monitored along with all other resident for nail care and hand washing prior to meals since citation on 10/13/2011.</p>	

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F 312	<p>Continued From page 11</p> <p>observed in her recliner in the hallway just outside the Restorative Dining Room. Fingernails on both hands were observed to have black matter beneath the nails. Referring to her fingernails, the resident stated, "They're dirty."</p> <p>At 12:38 PM Resident #39 was moved into the Restorative Dining Room by staff and positioned at a table for dining. At 12:49 PM staff set up the resident's tray for her so she could feed herself. No staff was observed to wash or check the resident's hands during this time. Resident #39 reached for a dinner roll, broke a piece off with her fingers, and began eating it. She continued to feed herself with occasional set up assistance from staff.</p> <p>On 10/10/11 at 6:15 PM, Resident #39 was observed in her bed at dinnertime. Her fingernails on both hands were again observed to have black matter beneath them. Staff set up the dinner tray for the resident but did not wash or check her hands. Resident #39 began to feed herself.</p> <p>On 10/12/11 at 9:40 AM, Resident #39 was again observed in her recliner. Her nails were in the same condition as the previous day.</p> <p>On 10/12/11 at 11:35 AM, Resident #39 was again observed in her recliner in her room. All fingernails on both hands were observed to be clean. A family member of the resident stated the resident had had a shower that morning.</p> <p>On 10/13/11 at 11:36 AM, Nursing Assistant (NA) # 4 was interviewed. NA #4 stated that fingernails were routinely cleaned on shower days, but that they were expected to clean fingernails anytime</p>	F 312	<p>Resident #36 was shaved on 10/13/2011; resident has also been monitored as well as other residents for need for facial hair removal.</p> <p>In-service given on 10/19/2011, to review the expectations of when and how nail care, resident hand washing, facial hair removal was to be completed along with who would be held accountable for each area.</p> <p>In-services on this topic will continue on 11/2/2011 and 11/9/2011. The following corrective action has been implemented for those residents having potential to be affected by the same deficient practice:</p> <p>Residents that eat in their rooms will have hands washed prior to eating by a staff member with a clean, warm, soapy washcloth.</p> <p>Washcloths, basins with warm water and soap, will be available for staff assigned to each dining area. Resident's hands will be washed prior to eating.</p> <p>A nail care kit has been created to assist staff with the equipment that is needed to properly complete nail care. These include fingernail clippers, emery boards and orange sticks.</p> <p>C.N.A.'s assigned to a resident is expected to ensure residents facial hair is removed when they are showering and as needed on a daily basis. Each C.N.A. will clean fingernails and wash hands on shower days, upon resident rising and before each meal as needed.</p> <p>Medication Aides and/or Hall Staff Nurses will monitor the overall appearance of the resident they are assigned to during their shift.</p>	

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F 312	<p>Continued From page 12</p> <p>they needed it. She stated it was part of the daily routine for NAs to check fingernails and wash hands before meals. She stated that Resident #39 was new to the hall and this was the third day she had cared for her. She stated she had cleaned the resident's fingernails yesterday during her shower. She stated she had not noticed that her fingernails needed cleaning the day before her shower.</p> <p>On 10/13/11 at 11:49 AM, Licensed Nurse (LN) #1, who was the nurse for Resident #39, was interviewed. She stated that showers were designated times for nail care, but that fingernails should be cleaned by NAs whenever they needed cleaning as part of daily routine. She stated she was not aware that NAs routinely washed resident's hands before meals.</p> <p>On 10/13/11 at 12:00 noon, the Director of Nursing (DON) was interviewed. She stated that she expected fingernail care to be completed on shower days, but also as needed anytime. She stated she expected staff to look at fingernails daily. The DON stated staff were supposed to ensure residents' hands were washed before meals and that staff should have seen the dirty fingernails of Resident #39 if her hands had been washed before the two meals.</p> <p>2. Resident #36 was admitted to the facility with diagnoses of dementia and palliative care, among others. The latest Minimum Data Set, dated 08/08/11, revealed the resident had severe cognitive impairment and required extensive assistance with most activities of daily living, including hygiene. A review of her care plan, revised in August 2011, revealed that the resident</p>	F 312	<p>Medication Aides and/or Hall Staff Nurses will document on the resident assignment sheet each shift that they have checked each resident for nail cleanliness and facial hair removal. They will document any action and follow-up that was needed.</p> <p>The completed resident assignment sheet will be given to the Charge Nurse who will review and forward to the Director of Nursing.</p> <p>Director of Nursing will review the information weekly x one month in the interdisciplinary morning meetings and then monthly thereafter.</p> <p>Results of monitoring will be reported to the QAA Committee quarterly for ongoing review until compliance is sustained for the cited deficiency.</p> <p>Date corrective action will be complete.</p>	11/10/2011

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F 312	Continued From page 13 required staff assistance with activities of daily living. On 10/10/11 at 5:12 PM, Resident #36 was observed in her wheelchair in her room. The resident had dozens of long facial hairs along her jaw line, on her chin, and below her nose. Some hairs were approximately 1/2 inch long. On 10/11/11 at 8:15 AM, Resident #36 was observed in the Restorative Dining Room eating breakfast. Her facial hair was in the same condition as on the previous day. On 10/12/11 at 1:45 PM and on 10/13/11 at 10:30 AM, Resident #36 was again observed to have facial hair in the same condition. On 10/13/11 at 11:43 AM, Nursing Assistant (NA) #5 was interviewed. She stated she worked on the hall where Resident #36 resided. NA #5 stated that female residents had facial hair trimmed on shower days. On 10/13/11 at 11:49 AM, Licensed Nurse #1, who was the nurse for Resident #36, was interviewed. She stated NAs should check facial hair daily for all residents and shave or trim it as needed. On 10/13/11 at 12:00 noon, the Director of Nursing (DON) was interviewed. She stated she expected facial hair to be checked and trimmed on shower days, but also as needed anytime. She stated she would expect staff to check facial hair on Resident #36 and trim it as needed.	F 312			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	<p>Continued From page 14</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and medical record review the facility failed to provide proper technique during incontinence care and implement measures to maintain continence for two of three residents observed for incontinence. Resident #9 and #45.</p> <p>The findings are:</p> <p>A review of Resident #9's medical record was conducted. Resident #9's most recent Minimum Data Set (MDS) dated 09/15/11 revealed she was cognitively impaired. The MDS further assessed Resident #9 as needing extensive assistance with toileting and being frequently incontinent of urine. Review of Resident #9's laboratory results revealed that on 09/30/11 a urinalysis with culture and sensitivity was conducted. Results of the urinalysis were positive for bacteria. On 10/02/11, the results of the culture and sensitivity revealed Escherichia coli (bacteria). On 10/02/11, Resident #9 was treated with antibiotics for a urinary tract infection.</p>	F 315		

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F 315	<p>Continued From page 15</p> <p>A review of the facility's policy entitled Female Perineal Care 08/02/07 was reviewed. This policy read in part, "Always wash the perineal area from front to back to prevent fecal contamination of the vulva. Use a long, gentle stroke from the front and back toward the rectum."</p> <p>An observation was conducted on 10/12/11 at 11:23 AM of incontinence care for Resident #9 done by Nursing Assistant (NA) #3. Resident #9 was on the commode in the shower room. Resident #9 stood holding to the bar as NA #3 performed care. NA #3 using a wet cloth and soap, cleaned Resident #9's buttocks and anal area, wiping front to back. Then using a different wash cloth NA #3 rinsed her buttocks and anal area front to back. NA #3 then cleaned Resident #9's peri-area, wiping back to front with a soapy wash cloth. He then rinsed her peri area, wiping back to front and dried her peri-area wiping back to front.</p> <p>An interview was conducted on 10/12/11 at 11:39 AM with NA #3. NA #3 reported he cleaned Resident #9 back to front using a different wash cloth to wash and rinse. NA #3 repeated this twice and then said but I should have cleaned her peri-area front to back.</p> <p>An interview was conducted on 10/13/11 at 3:45 PM with the Assistant Director of Nursing/Staff Development Coordinator. She reported that when staff are hired they are given a copy of the expected competency of incontinence care. She further reported it was her expectation that a female resident is cleaned wiping front to back.</p>	F 315	<p>To correct the cited deficiency, the facility will reeducate, monitor, evaluate and implement systems to promote proper techniques during incontinence care and implement measures to maintain continence.</p> <p>All nursing staff members will be required to attend an in-service on proper techniques of peri-care and incontinence evaluation and care. Dates of classes are: 10/19/2011, 11/2/2011</p> <p>Resident #9 was reassessed while incontinent care was being provided until each caregiver was proficient in female incontinence care. Each caregiver was educated on proper technique in the October 19th Staff meeting and on each incontinent episode until all staff was assessed for proper technique.</p> <p>NA#3 was given documented re-education prior to giving care to another resident.</p>		

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F 315	<p>Continued From page 16</p> <p>An interview was conducted on 10/13/11 at 3:52 PM with the Director of Nursing. She reported her expectation of incontinence care was washing a female front to back using soap, rinsing and drying well.</p> <p>2. Resident # 45 was admitted to the facility with diagnoses which included hypertension, benign prostatic hypertrophy without urinary obstruction and Alzheimer's disease. Current physician's orders included Lasix 60 (sixty) milligrams (mg) daily and Flomax 0.4mg daily.</p> <p>The most recent Minimum Data Set (MDS) was a quarterly assessment dated 09/14/11. Resident # 45 was assessed as having Impaired short term and long term memory and severe cognitive impairment. He was also assessed as requiring extensive assistance of two (2) staff with toileting and transfers and as always incontinent of bladder and frequently incontinent of bowel. The previous MDS was a quarterly assessment dated 06/21/11 which assessed him as having impaired short term and long term memory and moderate cognitive impairment. He was also assessed as requiring extensive assistance of two (2) staff with toileting and transfers and as always continent of bladder and bowel. Further review of the medical record revealed that no additional assessment was completed to evaluate the cause for significant decline in the resident's continence status. No documentation was available to indicate that resident had been assessed for a pattern to his incontinent episodes.</p> <p>A review of the current Care Plan for Resident #</p>	F 315	<p>Resident #45 identified as a high risk for skin breakdown due to impaired mobility and incontinence was reassessed and the care plan was revised to address urinary incontinence. Resident was then referred to Restorative Nursing to initiate a toileting program, work on transfers, and active range of motion for upper extremities and passive range of motion to lower extremities with plan of care updated.</p> <p>Staff Nurses will be required to observe 4 C.N.A.'s or Medication Aides providing peri care to at least 8 different resident each shift x 4 weeks. Staff Development Coordinator will complete competence on all C.N.A.s, Med Aides and Nurses by 11/9/2011. The staff Nurses will report their continence observations to the Staff Development Coordinator via Competence Evaluation Form.</p>		

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F 315	<p>Continued From page 17</p> <p>45 revealed the following problem statement "High risk for skin breakdown due to impaired mobility and Incontinence." The interventions listed did not identify any specific interventions to address incontinence.</p> <p>Continuous observation of Resident # 45 on 10/10/11 from 12:18 PM until 1:05 PM revealed he was sitting in the facility's main dining room feeding himself lunch. When he exited the dining room at 1:05 PM a puddle of yellow liquid was observed in front of the table where his wheelchair had been sitting.</p> <p>Observation of Nursing Assistant (NA) # 2 providing incontinence care to Resident # 45 on 10/10/11 at 1:08 PM revealed the incontinence brief was saturated with urine and came apart while being removed from the resident. The fleece pants he was wearing were wet across the back and midway down the back of both legs. The vinyl cushion in the wheelchair was also visibly wet.</p> <p>Observation of NA # 1 toileting Resident # 45 on 10/12/11 at 8:25 AM revealed his incontinent brief was dry when he was placed on the commode. NA # 1 placed the call bell in his hand and told him to ring when he was finished. He rang within five (5) minutes and was assisted back into his wheelchair.</p> <p>Additional observations of Resident # 45 on 10/11/11 at 8:48 AM and 11:14 AM, on 10/12/11 at 11:36 AM and on 10/13/11 at 8:10 AM revealed he had no odor of urine or other signs of incontinence.</p>	F 315	<p>The Staff Development Coordinator will compile a report weekly to Director of Nursing. Director of Nursing will report weekly findings to a multidisciplinary morning meeting x 1 month.</p> <p>The Staff Development will report results quarterly to the QAA Committee with the Infection Control Report to track effectiveness.</p> <p>The following corrective action has been implemented for all those residents having potential to be affected by the same deficient practice: i.e. toileting program:</p> <p>The MDS Coordinator and Care Plan Nurse/Restorative Nurse will be responsible to oversee assessment, initiation and review of toileting program.</p> <p>Residents will be added to a toileting schedule as assessed on admission and during quarterly and annual resident assessments.</p> <p>Restorative Nursing will be responsible for updating the list for residents that are on toileting schedules.</p> <p>Staff Nurse will check C.N.A. documentation on C.N.A. Assignment Sheet each shift for compliance with toileting program.</p> <p>Staff Development Coordinator will check C.N.A. documentation for toileting in E-Medical Record within 24 hours.</p> <p>Staff Development Coordinator/ADON will present toileting compliance in the Interdisciplinary morning meeting x 4 weeks</p>		

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F 315	<p>Continued From page 18</p> <p>Interview with NA # 1 on 10/10/11 at 1:16 PM, revealed she toileted Resident # 45 before lunch between 11:00 AM & 12:00 PM but she was unable to recall exactly what time.</p> <p>In an interview on 10/12/11 at 8:25 AM, NA # 1 stated Resident # 45 had a decline in his condition several months ago with an increase in confusion and incontinence. She stated he has recently shown some improvement and is usually continent of bowel. She further stated: "we try to check him more than every two hours because he voids a lot."</p> <p>In an interview on 10/12/11 at 11:29 AM, NA # 2 stated Resident # 45 has had a decline over the past six (6) months and is always incontinent of urine but most of the time is continent of bowel. She stated he asks to be taken to the toilet first thing in the morning.</p> <p>In an interview on 10/13/11 at 1:57 PM with the Resident Assessment Nurse in regard to the coding of Resident # 45's continence status on the MDS, she stated she obtains information on continence status from the "Smart Charting" system used by the NA's. Review of documentation by the NA's for the observation period from 9/8 - 9/14/11 revealed documentation of number of incontinence episodes per shift but didn't document specific times. The MDS nurse was unable to provide documentation that an assessment was completed to evaluate for a pattern or cause for the change from always continent of bladder on the 06/21/11 quarterly MDS to always incontinent of bladder on the 09/14/11 quarterly MDS. The MDS nurse was unable to provide documentation that Resident #</p>	F 315	<p>Staff Development Coordinator/ADON will present toileting compliance in the Interdisciplinary morning meeting x 4 weeks</p> <p>Toileting compliance will also be presented in monthly Restorative/Continence Meeting.</p> <p>Director of Nursing will compile a toileting report for quarterly QAA Committee for continued tracking and effectiveness of program.</p> <p>Date of completion of corrective action</p>	11/9/2011

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F 315	<p>Continued From page 19</p> <p>45 was on any type of toileting program to try to restore bladder continence.</p> <p>In an interview on 10/13/11 at 2:23 PM, the Director of Nursing (DON) stated Resident # 45 has had a significant overall decline mentally, functionally & physically and had a decline in transfer status and in independence with toileting. The DON also stated he has been showing some improvement & has been able to tell staff when he needs to void. The DON stated he wasn't put on a continence program & he wasn't assessed by the Nurse Practitioner, who was overseeing the facility's continence program.</p> <p>In an interview on 10/13/11 at 2:52 PM with the DON about her expectations for adjustment to a resident's plan of care whenever there is a significant decline in the resident's continence status: she stated she would expect for a complete new assessment to be completed that should include an evaluation of whether the resident had the potential to be retrained or if they needed a scheduled toileting program based on input from the NA's on his voiding pattern. She also stated she would expect the change to be reflected in the written plan of care including the "Care Tracker" system used by the NA's.</p>	F 315		
F 371 SS=E	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371	<p>To address the cited deficiency the facility will ensure that expired foods will be discarded and not available for use and that foods in dented cans will not be available for use and foods will be stored properly.</p> <p>On 10/10/2011 all cans of expired goods were discarded. All dented cans were discarded.</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that expired foods were discarded and not available for use, that foods in dented cans were not available for use and that foods were stored properly. The findings are: Observations of the kitchen's food storage areas on 10/10/11 beginning at 10:38 AM with the assistant Food Service Manager (FSM) revealed the following concerns: 1. Seven (7) 27 oz cans of green chiles with an expiration date of 9/25/11 were on the shelf with other canned foods available for use. Interview with the assistant FSM on 10/10/11 at 11:20 AM confirmed the expired cans were in the food storage area with food available for use. 2. Sixteen (16) dented cans of food were on the shelf with other canned foods available for use: three (3) 117 ounce (oz.) cans cranberry sauce - two (2) with dents on the side extending into the rim; one (1) 105 oz. can sliced pears with a dent on the bottom rim; one (1) 115 oz. can ketchup; four (4) 6lb. 11oz. cans crushed pineapples - all four (4) cans had dents that involved the rims; two (2) 6lb. 10oz. cans sliced peaches - both cans had dents in the rims; one (1) 6lb. 8oz. can sliced apples which had a large dent in the rim; two (2) 110 oz. cans three bean salad - both cans had dents in the rims; one (1) 101 oz. can cut green	F 371	The Cereal scoop was removed immediately from the dry cereal container. New policy written to reflect procedures for handling dented cans and an infection practice for handling scoops in dry goods. Dietary staff was in serviced on new policy and new audit forms on 10/17/2011. A new audit form was created to document food shipments received was implemented to document invoice #, vendor, delivery date, damaged goods, number of items, vendor called if damaged goods and returned for credit. An Audit Tool for monthly food audits implemented that document non-perishables and expiration date, perishables and expiration date and dry goods and expiration date. Audits will be completed daily by Food Service Director or her designee. Weekly reports will be given to the interdisciplinary team x 4. +Monthly reports will then be given to the Administrator or Assistant Administrator. Quarterly reports will be submitted to the QAA Committee for evaluation and effectiveness of the cited deficiency .Correction Action Completed 1	11/1/2011	

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F 371	<p>Continued From page 21</p> <p>beans which had a large dent in the rim & one (1) 106 oz. can whole kernel corn which had a dent in the rim.</p> <p>Interview with the assistant FSM on 10/10/11 at 11:20 AM confirmed the dented cans were in the food storage area with food available for use. She indicated a separate area where six (6) dented cans were stored which were to be returned to the food vendor. She stated the cans should have been put with the other dented cans to be returned to the food vendor. All sixteen (16) dented cans were removed by the assistant FSM & placed with items to be returned to vendor.</p> <p>3. Seven (7) dented cans of food on the shelf designated for "Foods to be used in a Disaster" Included: six (6) 51 oz. cans of corned beef hash - five (5) with dents involving the rim and one (1) 4 pound (lb) 2 1/2 oz. can of chunk tuna in water with a dent in the rim.</p> <p>Interview with the assistant FSM on 10/10/11 at 11:20 AM confirmed the dented cans were in the food storage area with food available for use in a disaster if normal food deliveries were interrupted. She indicated a separate area where six (6) dented cans were stored which were to be returned to the food vendor. She stated the cans should have been put with the other dented cans to be returned to the food vendor. All seven (7) dented cans were removed by the assistant FSM & placed with items to be returned to vendor.</p> <p>4. A plastic bin containing dry cereal had a scoop stored in the container with the handle of the scoop touching the cereal. Interview with the assistant FSM on 10/10/11 at 11:20 a.m.</p>	F 371			

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F 371	Continued From page 22 confirmed the scoop should not have been stored in the container. In an interview with the assistant FSM on 10/12/11 at 8:41 AM about who is responsible for removing dented cans for return to vendor she stated: "I am & if I'm not here the Food Service Manager is." She stated she thinks the dented cans may have been missed because they have been working one staff member short so sometimes the person putting up stock on Tuesdays & Thursdays gets pulled to help in the kitchen. An interview with the assistant FSM on 10/13/11 at 11:40 AM revealed there is no written policy & procedure for handling of dented cans or storage of scoops in dry goods.	F 371		
F 431 SS=E	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	F 431	To resolve the cited deficiency for failure to remove expired medications from medication stock storage and medication carts and failure to ensure expiration dates were visible on resident medications. Also failure to ensure containers of resident medications was securely closed while stored in medications. All Medications that were noted to be expired, not properly labeled with expiration dates and medications that were not stored securely in cubes were sent back to the Pharmacy for proper disposition on 10/11/2011 and 10/12/2011 To resolve the cited deficiency:	

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F 431	<p>Continued From page 23</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to remove expired medications from medication stock storage and medication carts, failed to ensure expiration dates were visible on resident medications, and failed to ensure containers of resident medications were securely closed while stored in medication carts in one (1) of one (1) medication storage rooms.</p> <p>The findings are:</p> <p>A review of a facility policy titled "Medication Audit - Protocol" dated September 2010 stated in part any medications that are close to expiration will be removed as feasible and sent to the Pharmacy for disposal.</p> <p>1. Inspection of the main medication room on 10/12/11 at 9:26 AM revealed:</p>	F 431	<p>Pharmacy to check all medications for proper labeling of medications prior to being dispensed. This includes correct expiration dates and proper cubical packaging. Pharmacy to replace cubes if tops is broken prior to dispensing to Nursing.</p> <p>Medication Aides will inspect carts on each shift for expired medications. Medications are not to be given if expiration is not on label or if medication has expired. Medications without expiration dates will be sent back to pharmacy for proper labeling. Any expired medications will be send back to pharmacy for disposal per policy.</p> <p>7p-7a nurses will check medication carts, refrigerators and stock medications once a week to check for expired, non-labeled and improperly stored medications on Monday night of each week.</p> <p>Pharmacy will check medication carts once a week on Friday of each week for expired, non-labeled and improperly stored medications.</p> <p>In-service on expired medications, non labeled medications and improperly stored On 11/2/2011 and 11/9/2011. Nurses and Medication Aides to attend at least one in-service.</p> <p>Medication Aides will document audits daily and give to Charge Nurse. Nurses on 7p-7a shift on Mondays will document their audit and in Director of Nursing box for review. Pharmacy will document their audit on Friday of each week and give report to Director of Nursing.</p>		

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F 431	<p>Continued From page 24</p> <p>a. The stock storage cabinet contained one (1) bottle of Loperamide Hydrochloride 2 milligrams with a pharmacy label on the bottle that indicated it was filled on 10/11/10 and expired on 10/11/11.</p> <p>b. The medication cart for A-Hall contained one (1) bottle of Glucose tablets 4 grams with a pharmacy label that indicated it was filled on 6/18/10 and expired on 6/11/11.</p> <p>During an interview with The Staff Development Coordinator she verified the pharmacy labels indicated both bottles of medications were expired. She stated the pharmacy had instructed nursing staff to check the expiration date on the pharmacy label and to also look for a manufacturer's expiration on the bottle. She stated she attempted to remove the pharmacy label on the Glucose tablets to look for a manufacturer's expiration date but was unable to remove the pharmacy label and could not find a manufacturer's expiration date on the bottle. She further stated the Glucose tablets were last administered to a resident on 07/22/11 and confirmed the medication was given after the expiration date listed on the pharmacy label.</p> <p>During an interview with Medication Aide # 1 on 10/12/11 at 10:10 AM she stated each nurse or medication aide should check expiration dates on medications before they gave them. She further stated if medication was expired they should remove it from the storage cabinet or medication cart and send it back to the pharmacy for replacement.</p> <p>During an interview with a Pharmacy Technician on 10/12/11 at 10:21 AM she stated the pharmacy labels each medication with the</p>	F 431	<p>Director of Nursing will prepare reports for Pharmacy weekly meetings x 4 weeks, monthly meetings x 3. Evaluation of the plan of correction will be conducted weekly and quarterly report to the Medication Advisory Committee will be ongoing to monitor effectiveness of the plan.</p> <p>Corrective action will be completed</p>	11/9/2011

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F 431	<p>Continued From page 25</p> <p>resident's name, drug name, fill date and expiration date. She stated nursing staff was expected to check the expiration dates and should return all expired medications to the pharmacy for replacement. She further stated if the expiration date was missing on the pharmacy label the nurses should also look on the container for the manufacturer's expiration date. She verified there should be an expiration date on every medication regardless of where it was stored.</p> <p>During an interview with the Director of Nurses (DON) on 10/12/11 at 10:44 AM she stated it was her expectation for nursing staff to check medications for expiration dates and send them back to the pharmacy when they were expired and they should not be given to residents.</p> <p>2. An inspection of the main medication storage room and medication carts on 10/12/11 at 10:10 AM revealed:</p> <p>a. The stock storage cabinet contained one (1) bottle of Vitamin D 1000 units with a pharmacy label that indicated it was filled on 9/26/11 but there was no expiration date on the label or on the bottle.</p> <p>b. The medication cart for A-Hall contained one (1) tube of Premarin vaginal cream with a pharmacy label that indicated it was filled on 8/10/11 but there was no expiration date on the pharmacy label or on the tube of medication.</p> <p>c. The medication cart for C-Hall contained one (1) bottle of Multivitamins but the expiration date was not visible on the label or on the bottle and the cart contained one (1) bottle of Bisacodyl 5 milligram tablets but there was no expiration date on the bottle.</p>	F 431			

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F 431	<p>Continued From page 26</p> <p>d. The medication cart for D-Hall contained one (1) bottle of Lidocaine 10 milligrams per milliliter that was opened and did not have an expiration date.</p> <p>During an interview with the Staff Development Coordinator on 10/12/11 at 9:26 AM she stated it was the responsibility of each nurse or medication aide to check expiration dates on medications before giving them to residents. She explained the date should be clearly marked but if not it should be sent back to the pharmacy for re-labeling.</p> <p>During an interview with Medication Aide # 1 on 10/12/11 at 10:21 AM she stated the medication aides were expected to look at expiration dates on each medication every day. She further explained the night shift nursing staff checked all medications in the storage room for expired dates every month. She stated they were expected to return any expired medications to the pharmacy for replacement before they gave it to a resident.</p> <p>During an interview with a Pharmacy Technician on 10/12/11 at 10:10 AM she stated each resident's medication should have a printed pharmacy label with the expiration on them. She verified sometimes the expiration date was cut off when the pharmacy printed the labels and the expiration date would not be visible on the container. She stated the nursing staff should have returned these to the pharmacy so they could have been reprinted with the expiration dates on them.</p> <p>During an interview on 10/12/11 at 10:44 AM with the Director of Nurses (DON) she stated she expected the pharmacy to put the expiration date</p>	F 431			

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F 431	<p>Continued From page 27</p> <p>on the label and nursing staff should verify the expiration date on the label before the medication was administered to a resident.</p> <p>3. Inspection of the medication carts in the medication room on 10/12/11 at 10:10 AM revealed:</p> <p>a. The medication cart for A-Hall contained one (1) box of Tramadol 50 milligrams in a drawer with the top of the plastic box missing and pills were exposed.</p> <p>b. The medication cart for C-Hall contained one (1) box of Promethazine 25 milligram tablets in a drawer with the top of the plastic box missing and pills were exposed. There was also one (1) box of Meclizine 25 milligrams and the top of the plastic box was missing with pills exposed.</p> <p>c. The medication cart for B-Hall contained one (1) box of Namenda 10 milligrams with the top of the plastic box missing with pills exposed.</p> <p>During an interview with Medication Aide # 2 on 10/12/11 at 10:35 AM she stated the tops of the plastic boxes "come off all the time and we can't get them to stay on." She verified medications in plastic boxes without tops could spill out into the medication drawers. She stated they should return any open containers to the pharmacy to get tops put on them.</p> <p>During an interview with the Staff Development Coordinator on 10/12/11 at 10:35 AM she verified there were open plastic containers of medications stored inside the medication carts. She stated nursing staff should have sent these back to the pharmacy for replacement. She verified the medications without tops could spill into the drawers of the medication carts and stated</p>	F 431			

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F 431	Continued From page 28 medications should not be stored with the tops off and exposed to air or contamination. During an interview on 10/12/11 at 10:44 AM with the Director of Nurses (DON) she stated it was her expectation for resident medications to have a top on them that was kept closed and they should not be open and exposed to air or other possible contamination. She stated nursing staff should have sent the open medication containers to the pharmacy for replacement.	F 431			