

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

PRINTED: 02/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2015
NAME OF PROVIDER OR SUPPLIER WILDFLOWER COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SALMON CREEK LANE JUNEAU, AK 99801		
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 2/2-5/15. The sample included 14 residents which included 5 closed records.</p> <p>State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503</p> <p>Abbreviations used in this document:</p> <p>DON - Director of Nursing RCC - Resident Care Coordinator IP - Infection Preventionist LN - Licensed Nurse CNA - Certified Nursing Assistant HRD - Human Resource Director FD - Facility Director POA - Power of Attorney IDT - Interdisciplinary Team MAR - Medication Administration Record PRN - As needed WFC- Wildflower Court DRR- Drug Regimen Review MD- Medical Doctor CAUTI - Catheter associated urinary tract infection</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *02/28/15*

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

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F 167 SS=F	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure that the most recent survey results were readily accessible to all residents without having to ask for them. In addition, the facility failed to post notice of the survey result's availability and location. This failed practice could potentially restrict resident access to the survey results and thereby denying them of their right to read the survey. Findings:</p> <p>Observation on 2/5/15 at 3:50 pm revealed that the most recent survey results were posted on a wall in the main hallway (Lupine Lane) in proximity to the chart room (room 9810).</p> <p>Observation on 2/2/15 at 10:30 am revealed Blueberry Place was a secured unit; meaning entry and exit access required an employee to enter a code to release the door. Residents living in Blueberry Place would not have unrestricted</p>	F 167	<p>It is the policy of this facility to respect the rights of our residents. As soon as the surveyor's concerns were reported to us, we immediately addressed her concerns. Social Services posted a notice in each of the four homes on 2/6/15. See Attachment A.</p> <p>Action(s) taken/systems put into place to reduce the risk of future occurrence include: The survey results location will be shared with the Resident/Family Group council and included in admission packets. How the corrective action(s) will be monitored to ensure the practice will not recur: Information is permanently and prominently posted in each home. Social services will update signage as needed.</p> <p>Person (s) responsible for compliance: Social Services, and/or designee. Share information regarding location of plan of correction with resident council and family council. Information will be in admission packets.</p> <p>Corrective Action completion date: 02/06/15.</p>	2/6/15	

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F 167	Continued From page 2 access to survey results without having to ask for them. During an interview with a family member on 2/4/15 at 2:00 pm, when discussing the survey process and access to the results in 90 days, the family member stated, "I didn't know we could see those." When asked if they knew where they could find the previous year's survey, they stated "No, I don't." Random observations from 2/2-5/15 revealed there were no notices or signage throughout the facility stating the survey result's availability and location. During an interview on 2/5/15 at 3:50 pm, the HRD confirmed that there were no notices posted informing residents and visitors of the survey result's availability and location.	F 167			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	It is the policy of this facility to minimize accidents and provide supervision of our residents. 1) Immediate action(s) taken for the resident #8 found to have been affected include: Appointment for resident #8 with a podiatrist was attempted, the resident refused and the physician was notified. During the course of the investigation for this deficiency we learned that an assessment was performed on the night of the event and no harm occurred. This assessment was not properly documented and resident refused further assessment. The Swiss army knife was removed (with permission of resident #8) and stored per policy until discharge. Resident #8 was discharged to an assisted living facility on 2/24/15.		

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F 323	<p>Continued From page 3</p> <p>by:</p> <p>Based on record review, interview, and observation the facility failed to ensure: 1) 1 resident (#8) out of 8 sampled residents were assessed from hazards related to the safe use of a knife; 2) residents were not exposed to toxic chemicals; and 3) an emergency call button in the resident's smoking area was operational. As a result, resident #8 was placed at risk for serious harm or injury due to the facility not assessing how the resident was using the knife; and hazards related to the use of undiluted toxic chemicals, for cleaning the resident's communal tub in one unit (Cranberry) of 4 units where residents utilized the communal tub, putting all residents who used the tub at risk for injury; and the emergency call button system in the resident's smoking area was non-functional, putting 2 of 55 residents at risk for injury. Findings:</p> <p>Safe Use of a Knife</p> <p>Record review from 2/2-5/15 revealed Resident #8 was admitted to the facility on 6/2/14 with a diagnosis that included Diabetes (persons with diabetes run a greater risk of circulatory problems, which could include a lack of blood to the feet).</p> <p>Review from 2/2-5/15 of LN #2's nurses note, dated 1/4/15 at 2:13 am, revealed "...[Resident] trying to cut his toenails with a kitchen knife [...] His toenails appear very thick, mycotic, and long...Tried to ask for the knife but won't give it..."</p> <p>Review of the medical record revealed no</p>	F 323	<p>The Administrator revised the Firearms and Other Weapons Administrative Policy to include residents. See attachment B</p> <p>Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Copies of the policy, Firearms and other Weapons, will be distributed to all staff by the Administrator. How the corrective action(s) will be monitored to ensure the practice will not recur: The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and updated plan of care is complete. Social Services will include the Firearms and other Weapons policy in the admission process. The Director of Nursing, or designee will complete random weekly chart audits for six (6) consecutive weeks and review all knife incident reports to ensure that appropriate interventions have been put in place to reduce the risk of accidents and that care plans have been updated to reflect these interventions. Audited records will be reviewed by the Quality assurance committee until such time consistent substantial compliance has been achieved as determined by the committee.</p> <p>Correction action completed date: March 22, 2015</p> <p>2) Immediate action(s) taken to ensure residents are not exposed to toxic chemicals: As soon as the surveyor's concerns were reported to us, we immediately addressed her concerns. The Facilities Director removed the bottles of chemicals from the tub rooms and placed the instructions on the use of the tub in the tub rooms on 02/04/15. Just-in-time training was conducted with the staff on how to clean the tub by the Facilities Director on 02/04/15. Proper cleaning procedure is posted in the tub rooms. See attachment C</p>	3/22/15	

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F 323	<p>Continued From page 4</p> <p>documented safety assessment, nor was there documentation Resident #8's toes had been assessed for injury.</p> <p>During an interview on 2/5/15 at 9:10 am, CNA #1 said she observed Resident #8 with a knife in his room sometime before Christmas. She reported it to the charge nurse. When she noticed the knife was still there, after the reporting, she reported it to LN #3. She said Resident #8 currently had a Swiss army knife in his room and was concerned he might use it to cut his toenails or cut himself.</p> <p>Random observations from 2/2-5/15 of Resident #8's room revealed a Swiss army knife on the bedside table.</p> <p>During an interview on 2/5/15 at 9:20 am, when asked about Resident #8 being in possession of a knife, LN #3 replied CNA #1 had reported it. The LN states it was reported to Charge Nurse #1. LN #3 stated she had never observed the "big knife". When asked about the Resident's current possession of a Swiss Army knife, the LN stated she was not aware he had one.</p> <p>During an interview on 2/5/15 at 9:25 am, when asked about the incident with Resident #8's knife, Charge Nurse #1 stated it was reported to Social Services Staff.</p> <p>Review on 2/5/15 at 2:30 pm of the summary of Resident #8's knife, from the Facility Director, dated 2/5/15, revealed he was notified on 1/15/15 Resident #8 had a knife in his room. After he spoke with RCC #1, the FD went to the Resident's room and took the knife. He said the knife was taken because of a safety issue. The knife, which was kept in the FD's office, was a</p>	F 323	<p>Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence included: All CNAs will be in-serviced on the facility procedure for cleaning the tubs and showers by the Facilities Director March 2 - 8, 2015. See Attachment D How the corrective action(s) will be monitored to ensure the practice will not recur: QAPI Nurse, or designee, will conduct weekly audits to ensure appropriate tub cleaning procedure. The nursing management team will review each incident report upon occurrence for accidents. Audits will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p> <p>Corrective action completion date: March 22, 2015</p> <p>3) Immediate action(s) taken to ensure emergency call button is working in the resident smoking area: As soon as the surveyor's concerns were reported to us, we immediately addressed her concerns. The batteries were changed on 02/02/15 on the call button and the receiver. The call button system was tested and found in working order by maintenance and the Facilities Director. Identification of other resident having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems in place to reduce the risk of future occurrence include: The facility procedure "PM Code" revised. Monitoring schedule implemented as follows: weekly check of the system will be performed at the same time the "smoking waste receptacle" is emptied. The procedure is: "W16. Check smoking trash cans & empty, 16A. Check intercom system</p>	3/22/15	

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F 323	<p>Continued From page 5 utility/kitchen knife with an 8 ½ inch blade.</p> <p>Record review from 2/2-5/15 revealed no documentation that Resident #8's feet were assessed for injury after the facility knew the Resident had used the 8 ½ inch blade utility knife to cut their toenails, despite the risk for impaired circulation due to diabetes.</p> <p>Undiluted Chemicals</p> <p>Observation of Cranberry's communal tub cleaning process on 2/4/15 at 8:40 am, revealed CNA #2 filled a spray bottle with undiluted Cen Kleen IV and sprayed the sides and bottom of the communal Prelude tub with the undiluted chemical. The CNA then stated the fumes were too strong to stay in the room. The CNA closed the door to the tub room, eliminating any cross ventilation and stated she would come back after 5 minutes to rinse the chemicals from the tub.</p> <p>The Surveyor, present in the tub room during the tub cleaning process, immediately began coughing in response to the undiluted chemical being sprayed in an enclosed space.</p> <p>During an interview on 2/5/15 at 11:00 am, the DON stated using undiluted Cen Kleen IV to clean the Residents' communal tub could be unsafe for both Residents and staff. The DON also stated it would be difficult to ensure the chemicals were completely rinsed from the tub and that the fumes were properly ventilated which would put both the Residents' skin and lungs at risk for injury when the communal tub room was used for their bathing.</p> <p>During an interview on 2/5/15 at 1:20 pm, the</p>	F 323	<p>The only permitted smoking area on campus is located outside of the Cranberry Cottage commons area. The receptacle in which smoking materials are disposed of is to be checked & emptied weekly, assuring all materials within are completely extinguished prior to placing material into the dumpster. 16A. In-order to assure communication between Smokers & staff inside the facility, a weekly test of the intercom system will be performed as follows: one staff member will inform their co-worker that they will activate the intercom system by pushing the "call button" in the smokers' enclosure, upon hearing the ringing at the cranberry C.N.A. desk the co-worker inside will attempt to initiate a conversation with the staff member outside. Once contact has been made both ways this test will be complete. Failing to have contact by both staff members will indicate a system failure, at which time no unsupervised smoking by residents will be allowed until the intercom has been repaired."</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur: Facilities Director, or designee, will keep a weekly log of the call light system test for the smoking area.</p> <p>Audited records will be reviewed by the QAPI Committee until such time consistent substantial compliance had been achieved as determined by the committee.</p> <p>Corrective Action completion date 02/02/15.</p>	2/2/15

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F 323	<p>Continued From page 6</p> <p>HRD stated the facility did not have a policy and procedure for cleaning the resident's communal tub.</p> <p>Review on 2/9/15 of the Cen Kleen IV website @ <http://arjocentury.com revealed, "Cen-Kleen IV [4] is a concentrated product and must be diluted for final use."</p> <p>Review on 2/9/15 of the Cen Kleen IV MSDS, dated 2/9/2009, revealed "Effects of overexposure: Skin: Burns...Eyes: Burns...Ingestion..."</p> <p>Emergency Call Button</p> <p>Record review from 2/2-5/15 revealed Resident #7 had been a resident of the long term care center for over 20 years. The Resident's current diagnoses included dementia; hepatic encephalopathy (confusion caused by liver failure); and being wheel chair dependent. The Resident was also a smoker.</p> <p>Multiple random observations from 2/2-5/15 revealed Resident #7 smoking alone in the resident smoking area.</p> <p>During an interview on 2/2/15 at 3:20 pm, Resident #7 identified the emergency call button on the wall of the Resident's smoking enclosure as the way to notify facility staff if help was needed while in the smoking area.</p> <p>During an interview on 2/4/15 at 9:15 am, Staff #2 confirmed the emergency call button on the wall of the Resident's smoking area was not functioning.</p>	F 323			

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F 323	Continued From page 7 When asked to provide the policy or procedure the facility followed to maintain the emergency call system in the smoking area, Staff #2 provided the "PM Code". Review on 2/4-5/15 of the procedure "PM Code", undated, revealed the batteries of the emergency call button were to be replaced in March of every year, but no monitoring was scheduled to guarantee the call system was functional throughout the year.	F 323		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	329 It is the policy of this facility to provide residents behavior monitoring and drug regimen free from unnecessary drugs. 1) Immediate action(s) taken for the resident(s) found to have been affected include: •Physician's orders for resident #1 and #6 were obtained on 2/23/15 to include the behaviors we are to monitor. •Care Plan updated to include behaviors monitoring for on resident #1. •Behavior monitoring forms implemented on 02/11/15 for residents #1 and #6: Behavior/Mood Symptom Tracking Tool and documentation of the specific behaviors observed include: date and time, behavior, cause, place, interventions and outcome. •Psychoactive Medication Evaluation each shift began on 02/23/15 •"Behavior Note" section added to our electronic medical record in the "ID Notes" section on February 25, 2015 for documentation of observed behaviors. •Care Conference documentation to include behavior monitoring and anti-psychotic medication effectiveness beginning on 03/12/15. Identification of other residents having the potential to be affected was accomplished by:	

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F 329	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents who were receiving medication to address inappropriate behaviors were adequately monitored and re-evaluated. Specifically, the facility failed to ensure: 1) targeted behaviors were identified and monitored for resident #'s 1 & 6; 2) physician was notified in a timely manner with escalation in behavior, and acted upon the increase in aggressive and assaultive behavior of 1 Resident (#6). As a result this placed 2 residents (#1 & 6) of 8 sampled residents at risk for receiving unnecessary medications and placed the resident at risk for adverse medication side effects. Resident #1 Record review from 2/2-5/15 revealed Resident #1 was admitted to the facility on 5/24/12 with diagnosis that included dementia with agitated psychosis. Medications included the antipsychotic Seroquel. Physician Orders (Targeted Behaviors) Record review from 2/2-5/15 of the "Physician's	F 329	The facility has determined that all residents receiving anti-psychotic drugs have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: All Licensed Nursing staff will be in-serviced regarding the facility policy for Unmanageable Residents, "Behavior Note" in the electronic medical record and the behavior monitoring forms listed above. See Attachment E How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing, or designee, will complete random weekly audits for six (6) consecutive weeks of behavior monitoring to ensure the behavior monitoring is documented and the physician is notified of escalating behaviors as needed. After 6 week audit period behavior documentation will continue to be monitored on a monthly basis. Audit records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 22, 2015. 2) Immediate action(s) taken for the resident(s) found to have been affected include: •Behavior monitoring forms were implemented on resident #6: Behavior/Mood Symptom Tracking Tool and documentation of the specific behaviors observed; Include - date and time; behavior; cause; place; interventions; and outcome on 02/11/15 •Psychoactive Medication Evaluation each shift on 02/23/15 •"Behavior Note" section added to our electronic medical record in the "ID Notes" section for documentation of observed behaviors on February 25, 2015. •The next Care Conference will include behavior monitoring and anti-psychotic medication effectiveness beginning on 03/12/15	3/22/15

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F 329	<p>Continued From page 9</p> <p>orders" dated 11/23/14, revealed the antipsychotic medication "Seroquel 25 mg [by mouth every] evening". The physician order did not indicate the behaviors to be monitor for effectiveness. Further review revealed the antipsychotic medication Seroquel had been increased on 12/29/14.</p> <p>Targeted Behaviors</p> <p>Record review from 2/2-5/15 of the "Consent for use of Psychoactive Medications" dated 11/24/14, for Resident #1 revealed, "Targeted Behaviors: anxiety, dementia" However, these are diagnoses and not behaviors. In addition the "Plans to decrease/discontinue medication" were left blank.</p> <p>Behavior Monitoring</p> <p>During an interview on 2/4/15, RCM #2 was asked to provide the LN and CNA behavior documentation from the first dose of the antipsychotic medication Seroquel was started, 11/23/14 through 2/4/15.</p> <p>Review of the documentation provided revealed, behaviors had only been documented by the LN on 9 days and by the CNA 12 days since the initiation of the antipsychotic medication. The Resident had been on the antipsychotic medication for 2 months and 11 days.</p> <p>During an interview on 2/4/15 at 3:00 pm RCM #1</p>	F 329	<p>Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents receiving anti-psychotic medication have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: All Licensed Nursing staff will be in-serviced regarding the facility policy for Unmanageable Resident on March 9 and 12, 2015. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing, or designee, will complete random weekly audits for six (6) consecutive weeks of behavior monitoring to ensure the behavior monitoring is documented and the physician is notified of escalating behaviors as needed. After 6 week audit period behavior documentation will continue to be monitored on a monthly basis. Audit records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p> <p>Corrective action completion date: March 22, 2015.</p>	3/22/15	

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F 329	<p>Continued From page 10 confirmed the dates of when behaviors were charted for Residents #1 were incomplete.</p> <p>In addition, RCM #1 disclosed the facilities process for reviewing resident behaviors was that the reviewer had to look at each resident's daily documentation from both the LN's and CNA's and was not very.</p> <p>RCM #1 further stated prior to the electronic charting system, residents behavior documentation was on a one page monthly form and was easily reviewed by all provider's. In addition, when the RCM was asked where the targeted behaviors were for the resident s/he stated "I'm not sure."</p> <p>Record review from 2/2-5/15 of the "Care Conference" note dated 12/11/14, revealed no documentation of any specific behavior monitoring or documentation the antipsychotic medication had been effective in decreasing behaviors.</p> <p>Record review from 2/2-5/15 of the "Care Plan" dated 11/26/14, revealed "[Resident name] has potential for harming others as evidenced by statements, gestures, and other incidents involving staff and/or residents." The approaches for the behavior were to "review current medications and treatments to determine a possible relationship." The care plan did not convey the need to monitor behaviors related to the antipsychotic medication.</p>	F 329		

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F 329	<p>Continued From page 11</p> <p>Resident #6</p> <p>Record review from 2/2-5/15 revealed Resident #6 was admitted to the facility on 9/1/09 with diagnoses to include dementia and anxiety. Medications included the antipsychotic Seroquel.</p> <p>During an interview on 2/2/15 at 11:35 am CNA #'s 1, 5 and 6 expressed concerns with the abusive behaviors of Resident #6. In addition, the CNA's stated they felt more should be done to control the combative and abusive behaviors because what they currently were doing was not working.</p> <p>Record review from 2/2-5/15 revealed Seroquel 25 mg [by mouth] was started on 2/17/14. Further review revealed an order date of 4/21/14 for a dose increase, "Seroquel 50 mg [by mouth] hour of sleep."</p> <p>Record review on 2/2-5/15 of the daily charting records dated 11/2/14 - 12/30/14, revealed 9 documented physical and verbal behavioral events in November 2014; 14 documented physical and verbal behavioral events in December. Further review revealed nursing was notified by the CNA's 4 times in December of the behaviors.</p> <p>In addition, review of the LN notes on 12/26/14 at 11:25 pm, revealed a significant escalation in</p>	F 329			

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F 329	<p>Continued From page 12</p> <p>behaviors. The medical record did not reveal documentation the physician had been notified of these new behaviors or that the escalation in behaviors had been discussed with the POA.</p> <p>Care Conference</p> <p>Record review from 2/2-5/15 of the "Resident Care Conference" dated 9/12/14, revealed "Increased agitation ...Very short tempered; verbally and physically abusive toward staff when providing care. Often non-compliant with care." Medication review revealed "currently taking Lexapro for treatment of depression and Seroquel for outburst behavior and anger...Will consult with MD for possible increase of Seroquel secondary to increased agitation."</p> <p>Further review of "Care Conference" dated 12/9/14, revealed "Increased behavioral disturbances ...Continues to exhibit aggressive behavior ...request for psychiatric evaluation has been initiated ...staff working with daughter to try and figure out what can be done ...[social service] will monitor new behaviors and work with team to figure out possible solutions to reduce them."</p> <p>Review of a faxed communication to the physician dated 9/9/14 revealed "Resident has been refusing medications and FSBS [finger stick blood sugars] at [night hour of sleep] x3 ...please advise." The physician wrote on 9/10/14 at bottom of fax sheet "Noted, just keep trying to give meds and document refusals."</p>	F 329			

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F 329	<p>Continued From page 13</p> <p>Review of a written "telephone encounter" communication dated 9/17/14, revealed a message was sent by RCC #1 to the physician stating "Pt has been having increased agitation and aggressiveness and care refusals ...Pt's [POA] is reportedly ok with considering Fentanyl or with Increasing Seroquel if needed." Physician noted "I will consider options and let them know next week."</p> <p>Further review of "Action Taken" dated 9/26/14 revealed the physician spoke with the POA regarding Fentanyl and risks also noting "If the Fentanyl patch doesn't seem to help with the pain or if it helps with pain but pt's behavior is still a problem, will consider other options including possibly increasing Seroquel dose or having Psychiatry see her..."</p> <p>Review of a written "telephone encounter" communication dated 10/24/14 revealed a message left for the POA of the resident to call back. Entries made on 10/31/14 revealed a conversation had taken place with the POA and the physician, "She [POA]commented on continuing behavioral issues and says when she comes back from travel, we might consider increasing Seroquel dose to help pt's anxiety/agitation, etc. I'll [Physician] see pt at WFC next week and make some changes."</p> <p>Physician Progress Notes</p>	F 329			

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F 329	<p>Continued From page 14</p> <p>Record review of Physician progress notes revealed the following, dated:</p> <p>"2/17/14, "Goal is improved quality of life and ability to receive appropriate/safe care from staff; [Started on Seroquel 25mg];</p> <p>4/21/14, no real [change] in angry outbursts, behaviors, etc. with addition of low dose Seroquel...[Assessment/Plan] Dementia with behavioral disturbances interfering with pt's quality of life and safe care by staff...will try [increased] dose of Seroquel. [Seroquel increased to 50mg];</p> <p>6/16/14, [increase] dose Seroquel +/- helping with behavioral disturbances;</p> <p>10/15/14, progressive dementia with behavior disturbances, overall pt really declining;</p> <p>11/4/14, considering increase dose Seroquel to help anxiety/agitation/behavioral disturbances...will monitor and consider further med changes depending on clinical course;</p> <p>12/19/14, Pt having increased agitation, labile behavior, spitting/kicking/screaming episodes that are impeding staff ability to care for her ... [assessment/plan] neuro/psyche at baseline has gradually worsening dementia with behavioral disturbances. Recently has had [increased]</p>	F 329			

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F 329	<p>Continued From page 15 behavioral changes with aggression, etc. that is interfering with her care."</p> <p>Review of the psychiatric consultation made for "combative behavior" dated 12/23/14, revealed "[patient] was interviewed...affect irritable ...avoids or confabulates answers ...complains of back pain...Recommendation: Begin gabapentin (anti-seizure medication) 100 mg [by mouth at hour of sleep]..." No indication for the use of Gabapentin was documented. Other recommendation was to use "validation technique to enhance communication."</p> <p>Interview</p> <p>During an interview on 2/3/15 at 10:00 am regarding Resident #6's behaviors, RCC #1 stated there was no pattern to the behaviors. When asked about documentation of the behaviors, the RCC stated there was not a form but that staff CNA's can write in the comments and nursing staff can make notes. The RCC stated nurses can view the CNA notes when needed and staff gives verbal reports to each other. When asked how the physician is notified of a resident's behavior, the RCC stated either by phone or by fax.</p> <p>During an interview with the DON on 2/3/15 at 12:45 pm, she confirmed there was not real pattern to the behaviors of Resident #6. The facility is trying different approaches to handle the behaviors but "what works one day or hour may not work the next time."</p>	F 329			

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F 329	Continued From page 16 Policy Review Record review from 2/2-5/15 of the facility policy "Antipsychotic Drug Administration", dated 6/28/05, revealed: "1. The decision to use antipsychotic drugs is based upon comprehensive assessments utilizing a multidisciplinary approach... 3. For organic mental syndromes with associated psychotic and/or agitated behaviors, ensure: the behaviors have been quantitatively (number of episodes)..., documented in the progress notes and is located on the medication monitoring sheet and on the behavior monitoring records... 6. Antipsychotic medication are monitored every shift for therapeutic and/or side effects on the medication monitoring record..." Record review from 2/2-5/15 of the facility policy "Aggressive Behavior by a Resident" dated 8/8/05, revealed "Resident and staff of Wildflower Court have the right to be free from mental and physical abuse...Members of the interdisciplinary Care plan team will evaluate the occurrence and implement care plan changes as indicated."	F 329			
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	1) All issues cited in the walk in cooler were remedied immediately on 02/02/15. The facility has determined all residents have the potential to be affected. The Food Services Director immediately reviewed hold times with all kitchen staff.		

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F 371	<p>Continued From page 18</p> <p>packages of Chocolate Breakfast Essentials with an expiration date of 1/21/15.</p> <p>During an interview on 2/3/15 at 7:55 am, CNA #1 stated the 2 packages of Chocolate Breakfast Essentials were outdated and should have been discarded.</p> <p>Review on 2/2-5/15 of the facility policy, "Food Storage, Handling and Preparation", dated 3/13/14, "To provide guidelines for food storage, preparation, cooking and serving using appropriate practices to ensure safety...The day the original container is opened shall be counted as Day 1...The use-by date for most foods in this category is three (3) days, with the exception of prepared gelatin, which is seven (7) days..."</p> <p>Sanitizing Solution</p> <p>During the initial kitchen tour on 2/2/15 at 11:10 am, Staff #1 identified a red bucket of solution as the sanitizing solution s/he was using to sanitize the food preparation counters between uses. When asked to demonstrate the process of checking the sanitizing concentration level, s/he identified the solution was at 0 on the Hydrion Strip and was not appropriate for sanitizing the food preparation counters. Staff #1 further stated there was not a log kept of the sanitizer solution levels.</p> <p>During an interview on 2/2/15 at 11:20 am the Kitchen Manager confirmed the facility did not monitor or maintain a log of the sanitizer levels.</p> <p>Review on 2/2-5/15 of the facility policy, "Cleaning and Sanitizing Food Contact Surfaces", undated,</p>	F 371			

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F 371	<p>Continued From page 19</p> <p>revealed "...Wash, rinse and sanitize food contact surfaces of sinks, tables, equipment, utensils, thermometers, carts and equipment...after each use..."</p> <p>Review on 2/9/15/ of the FDA food code @ <http://www.fda. revealed,</p> <p>"...3-304.11 Food Contact with Equipment and Utensils. FOOD shall only contact surfaces of: EQUIPMENT and UTENSILS that are cleaned as specified under Part 4-6 of this Code and SANITIZED as specified under Part 4-7 of this Code;</p> <p>4-602.11 Equipment Food-Contact Surfaces and Utensils. EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned...At any time during the operation when contamination may have occurred.</p> <p>4-701.10 Food-Contact Surfaces and Utensils. EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED. Frequency 4-702.11 Before Use After Cleaning. UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning. Methods 4-4-703.11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in...(C) Chemical manual or mechanical operations, including the application of SANITIZING chemicals by immersion, manual swabbing, brushing, or pressure spraying methods..."</p>	F 371			

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F 371	Continued From page 20	F 371			
F 428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the monthly drug regimen review consisted of recommendations to the physician for 5 residents (#s 1, 2, 3, 6 & 8) out of 8 resident records reviewed. Specifically the facility failed to: 1) ensure antipsychotic medications were monitored for effectiveness for 2 residents (#1 & 6); 2) report the overuse of an antibiotic ointment, which increased the resistance for resident #2; and 3) notify the physician and interdisciplinary team of medications for pain and sleep, had not been used in more than 60 days for resident #'s (3 & 8). This failed practice created the risk of residents receiving unnecessary medications, and placed residents at risk for adverse side effects. Findings:</p>	F 428	<p>It is the policy of this facility to provide pharmacist review of resident medications every 30 days. Immediate action(s) taken for the resident (s) found to have been affected include:</p> <p>1) A review of the medication regimen and identified irregularities was conducted by the Director of Nursing for resident(s) # 1 on 02/22/15 and #6 on 02/23/15. New consent forms were created that include behaviors to monitor and plan for discontinuation.</p> <p>2) A review of the medication regimen and identified irregularities was conducted by the Director of Nursing for resident(s) #2 on 02/22/15 and on 02/24/15. The antibiotic was DC'd.</p> <p>3) A review of the medication regimen and identified irregularities was conducted by the Director of Nursing for resident(s) #3 on 02/08/15 and found that he received a PRN dose of pain medication 04:15 a.m. that day. Monitoring for no use of prn pain medication in 60 day began on 02/08/15 for resident #3. A review of the medication regimen and identified irregularities was conducted by the Director of Nursing for resident(s) resident # 8 on 02/22/15. Irregularities were addressed and responses were documented. The physician was notified for those irregularities requiring MD notification. PRN ordered was DC'd. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence included: A policy and procedure regarding the timely review and action on identified medication irregularities as a result of the monthly Medication Monthly Review was developed on 02/24/2015 by the Director of Nursing. A copy of the policy was sent to the contracted pharmacist. The pharmacist will generate a monthly medication regimen review</p>		

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F 428	<p>Continued From page 21 Resident #1</p> <p>Record review from 2/2-5/15 revealed Resident #1 was admitted to the facility on 5/24/12 with diagnoses to include dementia and chronic pain.</p> <p>Record review from 2/2-5/15 of the "Physician's orders" dated 11/23/14, revealed the antipsychotic medication "Seroquel 25 mg [by mouth every] evening". The physician order did not indicate the behaviors to monitor for effectiveness.</p> <p>Further review revealed the antipsychotic medication Seroquel had been increased on 12/29/14. In addition, the medical record did not provide documentation of a discussion with the IDT or the POA regarding an increase in behavior and a subsequent increase in the dose of the antipsychotic medication.</p> <p>Record review of DRR completed by Pharmacist #1, dated 12/31/14 & 1/31/15, revealed "No adverse effects due to medication at this time. There are no discrepancies in the current drug regimen." The Pharmacist did not make a recommendation to the Physician that the behavior monitoring was inconsistent since the initiation. There was no documented review of the dose increase of the antipsychotic medication.</p> <p>Resident # 6</p> <p>Record review from 2/2-5/15 revealed Resident #6 was admitted to the facility on 9/1/09 with diagnoses to include dementia and anxiety.</p>	F 428	<p>report listing the resident's name, allergies, medications and indications for each medication with his recommendations for each resident and send to the Director of Nursing. The Director of Nursing will review the Addressing Medication Regimen Review Irregularities policy with the pharmacist, staff nurses, charge nurses and resident care coordinators on March 9 and March 12, 2015. See Attach. H. How the corrective action(s) will be monitored to ensure the practice will not recur: The Resident Care Coordinators will address any irregularities identified by the medication regimen within one week of receipt of the report. Documentation will be provided of the actions taken for each irregularity noted. The Director of Nurses, or designee, will review each Resident Care Coordinators report and corresponding documentation for (3) months to ensure compliance. Audits will be reviewed by the QAPI Committee until such consistent substantial compliance has been achieved as determined by the committee.</p> <p>Corrective action completion date March 22, 2015</p>	3/22/15

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F 428	<p>Continued From page 22</p> <p>Record review revealed, Seroquel 25 mg [by mouth]" was started on 2/17/14 and was increased to 50mg on 4/21/14.</p> <p>Record review of the DRR completed by Pharmacist #1 from 8/31/14 to 1/31/15, revealed "No adverse effects due to medication at this time. There are no discrepancies in the current drug regimen." The Pharmacist did not make recommendations to the Physician; nor address behaviors or possible need for increasing medication dosage.</p> <p>Record revoew of the Physician progress note dated: 4/21/14, "no real [change] in angry outbursts, behaviors, etc. with addition of low dose Seroquel ...[Assessment/Plan] Dementia with behavioral disturbances interfering with pt's [Resident #6] quality of life and safe care by staff ...will try [increased] dose of Seroquel";</p> <p>6/16/14, "[increase] dose Seroquel +/- helping with behavioral disturbances";</p> <p>10/15/14, "progressive dementia with behavior disturbances, overall pt really declining";</p> <p>11/4/14, "considering increase dose Seroquel to help anxiety/agitation/behavioral disturbances ...will monitor and consider further med changes</p>	F 428			

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F 428	<p>Continued From page 23 depending on clinical course";</p> <p>12/19/14, "Pt having increased agitation, labile behavior, spitting/kicking/screaming episodes that are impeding staff ability to care for her.. [assessment/plan] neuro/psyche at baseline has gradually worsening dementia with behavioral disturbances. Recently has had [increased] behavioral changes with aggression, etc. that is interfering with her care."</p> <p>Record review on 2/2-5/15 of the facility Pharmacist "Agreement", dated 1/1/15, revealed "will provide clinical services...in conformance with Federal & State regulations...,drug therapy will be evaluated for proper application and dosage...Any potential or current improper drug utilization will be identified and the proper health professionals will be consulted."</p> <p>During a telephone interview on 2/5/15 at 2:45 pm, Pharmacist #1 stated he relied on a verbal report from the RCM's on behaviors because the behavior monitoring documentation in the electronic record was not easily reviewed.</p> <p>Professional Reference</p> <p>Review on 2/9/15 at www.ascp.com revealed, "The American Society of Consultant Pharmacists supports the use of environmental modifications and non-pharmacologic approaches as initial therapy for the management of behavioral and psychological symptoms of dementia. The use of antipsychotics in nursing facility residents should include:</p> <ul style="list-style-type: none"> • An appropriate indication for use 	F 428			

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F 428	<p>Continued From page 24</p> <ul style="list-style-type: none"> · A specific and documented goal of therapy · Ongoing monitoring of the resident to evaluate effectiveness in achieving the therapy goal and the development or presence of adverse effects from the medication · Use of the medication only for the duration needed, and at the lowest effective dose." <p>Antibiotic Resistance</p> <p>Resident # 2</p> <p>Record review from 2/2-5/15 revealed Resident #2 was admitted to the facility with diagnoses that included bladder atony (non-emptying bladder) requiring an indwelling catheter (tube inserted into the bladder that drains into a bag) and diabetes.</p> <p>Record review from 2/2-5/15 of the "Physician's orders" dated 11/24/14, revealed, "Antibiotic (bacitracin zinc) 500 unit/gram Topical Ointment [bacitracin zinc] to urethral meatus QHS [every night] topical every HS [night]."</p> <p>Record review of the Resident's MAR for the time period of 1/1/15 through 2/2/15 revealed the antibiotic cream was applied to the Resident for 28 of the 33 days (the Resident refused the antibiotic cream on 5 days.)</p> <p>Record review of DRR completed by Pharmacist #1 dated 1/31/15, revealed "No adverse effects due to medication at this time. There are no discrepancies in the current drug regimen."</p> <p>During an interview on 2/5/15 at 11:00 am, the IP stated the continued daily use of the antibiotic</p>	F 428			

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F 428	<p>Continued From page 25</p> <p>cream for Resident #2 should have been discussed with the physician due to the increased risk of the Resident building up a resistance to the antibiotic.</p> <p>During a telephone interview on 2/5/15 at 2:45 pm, Pharmacist #1 stated the daily use of bacitracin would not be recommended due to the increased risk of antibiotic resistance.</p> <p>Review on 2/10/15 of the CDC website at www.cdc.gov</p> <p>"Do not clean the peri-urethral area with antiseptics to prevent CAUTI while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate."</p> <p>As Needed Medication</p> <p>Resident #3</p> <p>Record review of the most current MAR revealed the medication morphine concentrate 20mg/ml dose 0.5ml every 2-4 hours as needed, had not been given for 4 months.</p> <p>Record review of the "Physicians Order" dated 1/30/15, revealed "Any PRN medication not used for 60 days may be discontinued."</p> <p>Record review of the DRR dated 1/31/15 revealed, "No adverse effects due to medication at this time. There are no discrepancies in the current drug regimen." There was no</p>	F 428			

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F 428	Continued From page 26 recommendation to the Physician to review the need for continued use of the as needed medication. Resident #8 Record review of the MAR for Resident #8 revealed the medication Trazodone 25 mg at bedtime, as needed for insomnia had not been given for 2 months, December and January. Record review of the "Physicians Order" dated 1/30/15, revealed "Any PRN medication not used for 60 days may be discontinued." There was no recommendation to the Physician to review the need for continued use of the as needed medication. Record review of the DRR completed by Pharmacist #1 dated 1/31/15 revealed, "No adverse effects due to medication at this time. There are no discrepancies in the current drug regimen." During an interview on 2/5/15 at 2:45 pm, Pharmacist #1 stated the DRR consisted of alerting the physician to PRN [as needed] medications that had not been given in the last 60 days.	F 428			
F 431 SS=E	483.80(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	F 431	It is the policy of this facility to provide labeling of drugs and biologicals. Immediate action(s) taken for the resident(s) found to have been affected include: 1)The temperature logs were revised with 36 - 46 F range per the CDC Guidelines and WFC's Medication Refrigerator Temperature policy. The		

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F 431	<p>Continued From page 27</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and policy review the facility failed to ensure: 1) medication refrigerator temperatures were properly maintained for 4 out of 4 medication refrigerators reviewed on the residents' units and 2) 1</p>	F 431	<p>Medication Refrigerator Temperature policy was revised to include instructions for corrective actions for out of range temperatures per the CDC Guidelines. The CDC Routine Vaccine Storage and Handling Plan were implemented on 02/17/15.</p> <p>2)The vaccines were discarded on 02/26/15 and new supply will be obtained with proper labeling for refrigeration. The new vaccines will be refrigerated upon receipt. The CDC's Routine Vaccine Storage and Handling Plan were implemented on 02/09/15 and copy placed in the Supply Room on the counter above the refrigerator where the vaccines are stored. The refrigerator temperature log was updated for temperature checks twice a day and implemented on 02/18/15. The Medication Refrigerator Temperature policy was revised to include refrigerator temperatures of vaccines and include instructions for temperatures out of range (reference CDC's Routine Vaccine Storage and Handling Plan). See Attachment 1</p> <p>Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents receiving medications requiring refrigeration have the potential to be affected. Action taken/systems put into place to reduce the risk of future occurrence include: An in-service on the Vaccine Refrigerator Temperature Log sheet and Medication Refrigerator Temperature policy will be conducted on March 9 and March 12, 2015. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>1)The Medication Nurses will inspect all medications in the refrigerator for appropriate labeling and temperature on their assigned homes daily. The QAPI Nurse will inspect all medications in the refrigerators for appropriate labeling and temperature weekly for medication containers labeled for refrigeration to ensure appropriate storage on an on-going basis.</p> <p>2)The QAPI Nurse, or designee, will monitor the</p>		

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F 431	<p>Continued From page 28</p> <p>medication refrigerator temperatures, where vaccines were kept, was properly maintained. This failed practice had the potential to affect the integrity of medications and vaccines used for a vulnerable population, based on a census of 55. Findings:</p> <p>Medication Refrigerators on the Units</p> <p>Observations from 2/3-5/15 of the medication refrigerators, located in all 4 resident units, revealed a "REFRIGERATOR TEMPERATURE LOG", with "Acceptable temperature range is 35-40F" printed on the top of the log, for staff to document the temperatures of the refrigerators. An inspection inside the refrigerators revealed residents' medications.</p> <p>Review of the temperature logs, from 10/1/14 to 2/3/15, revealed numerous documented temperatures outside of the 35-40 F range. The logs also revealed numerous dates where no temperatures were documented. The logs also had "Corrective Action for Out of Range Temperature" on it with an area to document "Date, Action Taken, Initials". For many out of range temperatures there were no dates, actions taken, or initials documented.</p> <p>Vaccine Refrigerator</p> <p>Observations from 2/3-5/15 of the vaccines refrigerator revealed a "REFRIGERATOR TEMPERATURE LOG", with "Acceptable temperature range is 35-40F" printed on the top of the log, for staff to document the temperatures of the refrigerator. Inside the refrigerator revealed vaccines, which included Mantoux (TB vaccination); afluria (Influenza vaccine); and</p>	F 431	<p>vaccine temperature log and medication containers labeled for refrigeration to ensure appropriate storage on an on-going basis. This plan of corrections will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met. Corrective action completion date March 22, 2015.</p>	3/22/15	

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F 431	<p>Continued From page 29 Engerix-B (Hepatitis B vaccine).</p> <p>Review of the temperature logs, from 10/1/14 to 2/3/15, revealed multiple temperatures outside the specified temperature range and multiple dates where no temperatures were documented. The temperatures that were documented were taken once a day.</p> <p>Review of the vaccine inserts, on 2/5/15 at 9:25 am, revealed the vaccines should be stored at 36-46 degrees Fahrenheit (for Engerix-B and afluria) and 35-46 degrees Fahrenheit (for Mantoux).</p> <p>When questioned by the Surveyor on 2/3/15 at 1:15 pm, the DON confirmed there were temperature logs where temperatures were out of range and also some temperatures were not documented.</p> <p>Review from 2/3-5/15 of the facility policy "Medication Refrigerator Temperature", dated 10/27/08, revealed "...medications...must be stored at recommended temperatures so that they are maintained at peak effectiveness...temperature of the refrigerator in the medication room will be maintained between 36-46 degrees Fahrenheit. This value will be documented daily and recorded on the Medication Refrigerator Log." There was no process in the policy for the staff to follow if a medication refrigerator temperature was out of range. The policy's temperature range stated 36-46 degrees Fahrenheit and the temperature logs range stated 35-40 degrees Fahrenheit. The policy did not address refrigeration temperatures of vaccines.</p>	F 431		

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F 431	Continued From page 30 Review of the CDC guidelines for "Vaccine Storage and Handling", accessed online 2/11/15, revealed "...There are few immunization issues more important than the appropriate storage and handling of vaccines...Vaccines exposed to temperatures outside the recommended ranges can have reduced potency and protection...Vaccines are fragile. They must be maintained at the temperatures recommended by vaccine manufacturers...temperature monitoring of the storage unit(s) at least twice daily..."	F 431			