

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/19/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00154733</p> <p>Complaint IN00154733 – Unsubstantiated due to lack of evidence.</p> <p>Survey dates: September 15, 16, 17, 18, and 19, 2014.</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Diane Nilson, RN, TC Carol Miller, RN Rick Blain, RN Tim Long, RN</p> <p>Census bed type: SNF/NF: 80 Total : 80</p> <p>Census payor type: Medicare: 5 Medicaid: 61 Other: 14 Total: 80</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000279 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 22, 2014 by Randy Fry RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan to address interventions for behaviors for 1 of 3 residents on antipsychotic</p>	F000279	F279 It is the intent of this facility to use the results of the assessments to develop, review and revise the resident's comprehensive plan of care.	10/10/2014

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	<p>medications in a sample of 5 residents reviewed for unnecessary medications (Resident #74).</p> <p>Findings include:</p> <p>The record for Resident #74 was reviewed on 9/18/2014 at 2:30 P.M. Diagnoses included, but were not limited to, dementia with senile delusions.</p> <p>A current Physician's Order Sheet, signed by the physician on 8/6/2014, indicated Resident #74 was prescribed risperidone (antipsychotic medication) 0.25 mg (milligrams) by mouth at bedtime.</p> <p>A "Behavior /Intervention Monthly flow Record" for September 2014 indicated Resident #74's behaviors included, but were not limited to, uncontrolled crying, delusions, and hallucinations.</p> <p>A review of the current care plans for Resident #74 did not indicate there was a care plan with interventions addressing crying, delusions, or hallucinations.</p> <p>RN #7, identified as the facility Behavioral Health Manager, was interviewed on 9/19/2014 at 10:00 A.M. During the interview, RN #7 indicated Resident #74 was prescribed risperidone for crying, hallucinations and delusions.</p>		<p>1.What corrective actions will be accomplished for those residents found to have been effected by the deficient practice Resident #74 care plan has beenreviewed and revised to include interventions for behaviors.</p> <p>1.How other residents having the potential to be effected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>All residents receivingantipsychotic medications have the potential to be effected. All care plans of residentswith antipsychotic medications and displaying behaviors will be reviewed foraccuracy and updated if needed.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Nurse Practitioner will reviewresident #74 chart and history for accurate diagnosis. Social service will update behavior trackingforms to reflect resident's behaviors. Resident #74 care plan will update to reflect behaviors withinterventions. Nurses will bein-serviced on care plans and documenting behaviors on the tracking forms by10.10.14.</p> <p>1.How the corrective actions will be monitored to ensure the deficient practice will not recur.</p>				

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F000329 SS=D	<p>RN #7 reviewed Resident #74's record and indicated the resident did not have a care plan with interventions addressing the resident's behaviors.</p> <p>A current facility policy, entitled "Behavior Management Program", dated 12/2010, was provided by the Executive Director on 9/19/2014 at 8:15 A.M. The policy indicated "It is the intent of this facility to identify and assess complex behaviors in residents in order to develop effective behavior management plans." The policy further indicated "The Social Worker, or designee, shall initiate a behavioral assessment management plan when staff or the MDS (minimal data set assessment) process identifies certain behaviors." The policy also indicated the management plan would "identify appropriate interventions to manage identified behavior(s) and the discipline responsible for implementing interventions."</p> <p>3.1-25(a)</p> <p>483.25(l) 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</p>				<p>Behavior RN will monitor care plan and tracking sheets weekly X 3 and then quarterly thereafter. Behavior RN will report findings to the QA committee monthly X 3 and quarterly thereafter until substantial compliance is achieved.</p> <p>1. The CEO to ensure compliance 10.10.14.</p>		

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	<p>monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to monitor for the specific conditions (delusions and hallucinations) for which an antipsychotic medication was ordered, and failed to accurately monitor for the behaviors of continuous crying, anxiety, and restlessness, for 1 of 5 residents reviewed for Unnecessary Medications, Resident #59.</p> <p>Findings include:</p> <p>The record for Resident #59 was reviewed on 9/17/14, at 9:35 A.M., and indicated diagnoses including, but not limited to Dementia with behavioral disturbances, and atypical psychosis. A Current Physician order, dated</p>	F000329	<p>F329 It is the intent of this facility to 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, documented in the clinical record or identified by routine behavior monitoring.</p> <p>1. What corrective actions will be accomplished for those residents found to have been effected by the deficient practice Resident #59 had records reviewed by the Nurse Practitioner for medication evaluation, diagnosis analysis and assessment of behavior symptoms to be monitored.</p> <p>2. How other residents having the potential to be effected by the same deficient practice will be identified and what corrective action will be taken. All behavior</p>	10/10/2014

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	<p>8/19/2014, indicated the resident was receiving Seroquel (an antipsychotic medication), 50 milligrams, at bedtime, for psychosis.</p> <p>Further review of physician orders indicated the Seroquel had been discontinued on 7/1/14, Seroquel 25 milligrams at bedtime restarted on 8/5/14 for atypical psychosis, and increased to 50 milligrams at bedtime on 8/19/14.</p> <p>Review of the Behavior/Intervention monthly flow records for August, 2014, indicated the behaviors of Continuous crying and anxiety were being tracked. There was no documentation on the behavior logs until 8/11/14.</p> <p>Under continuous crying , "0"s were documented on day shift , between 8/12 and 8/31/14, which indicated no behaviors , with the exception of 3 days which were blanks.</p> <p>Evening shift documentation indicated blanks, except for 8/11, 12, and 21, 2014, which indicated "0" for no behaviors.</p> <p>On night shift there was documentation recorded on only one day, 8/27/14, which indicated "0" for no behaviors observed.</p> <p>The August 2014 documentation for tracking anxiety indicated there was nothing documented for day shift, only 2 days documented on evening shift , on</p>		<p>tracking forms will be reviewed and adjusted to assure that the all behaviors requiring monitoring are accurately reflected and monitored by 10.01.2014.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Behavior Health Nurse and Social Worker audited and verified that that all behaviors listed on behavior tracking forms accurately reflect the behaviors for which the antipsychotic medication is being utilized for by 10.01.14. Nursing staff will be educated in regards to correct completion of behavior monitoring sheets by 10.10.14.</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur. Behavior Nurse and/ or designee will monitor behavior sheets weekly X 3 weeks and DON and/or designee will spotcheck at least 4 times per month X 3 months and periodically thereafter. Audits will be discussed at the monthly behavior meetings and results will be discussed by the IDT at monthly Quality Assurance meeting until substantial compliance is achieved.</p> <p>5. The CEO to ensure compliance 10.10.14.</p>				

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	<p>8/11 and 8/21/14, which indicated "0" no behavior, and only one day documented on night shift, on 8/27/14, which indicated no behaviors.</p> <p>Review of nurse's notes indicated some of the behaviors were documented.</p> <p>Review of the nurse's notes for August, 2014, indicated the following entries related to behaviors:</p> <p>There was no documentation related to behaviors until an entry on 8/5/14, on the 3:00 - 11:00 P.M. shift, which indicated pleasant mood, no behaviors noted, no signs or symptoms of agitation due to room change. Also, started on Seroquel 25 milligrams, daily, for diagnosis of Atypical psychosis.</p> <p>Additional nurse's notes indicated the following:</p> <p>8/6/14 1500 - the resident was started on Seroquel last night, no behaviors noted this shift;</p> <p>8/7/14 1300 - no adverse effects from Seroquel, pleasant mood;</p> <p>8/11/14 1300 - Mood pleasant , no signs of anxiety</p> <p>8//12/14 2130 no changes in mood or behavior noted</p> <p>8/13/14 2200 - Pleasant and confused; CNA assisted the resident to bed and when she removed the resident's false teeth, the resident began screaming and attempting to pick the teeth up from the</p>			

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	<p>floor; difficult to re-direct the resident; 8/14/14 1300 - pleasant mood, no signs of anxiety; 8/14/14 2200 - Resident became agitated when assisted to bed, yelling and very focused on the pad under her because one side was white and the other blue. The resident removed the blanket, upset about it. The resident attempted to get out of bed because of the blanket and pad multiple times. The resident then complained of pain, given medication for the pain, and another medication given for restlessness once in bed; 8/15/14 3:00 - 11:00 P.M. shift - Pleasant mood, no behaviors noted; 8/16/14 3:00 - 11:00 P.M. shift - No behaviors noted; 8/24/14 3:00 - 11:00 P.M. shift - Pleasant mood, no behaviors; 8/25/14 (untimed) No signs or symptoms of anxiety; 8/28/14 1300 - The resident was very agitated while staff attempting to deliver bolus feeding and afternoon medication, grabbing at staff's hands , which caused some spillage, then spitting and screaming at staff about the mess on her. Staff maintained soft, low speech and the resident eventually quieted. 8/29/14 3:00 - 11 :00 P.M. shift - No changes in mood or behavior; 8/30/14 3:00 - 11:00 P.M. shift - No changes in mood or behaviors;</p>			

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	<p>8/31/14 11 - 7:00 A.M. shift - No signs or symptoms of agitation; 8/31/14 11:00 A.M. - Tolerating increase in Seroquel well.</p> <p>Between 8/1/14 and 8/13/14, there was no documentation of any behaviors related to continuous crying or anxiety. There were also numerous blanks on the behavior monthly flow records.</p> <p>Review of the behavior flow record for September 2014 indicated the following: Tracking for continuous crying indicated nothing was documented on day or evening shift, and only one day was documented on night shift, 9/16/14 which indicated no behavior. The tracking for anxiety and restlessness, indicated the following: On day shift: no behaviors on 9/2, 3, 8, 9, 10, 13, 15, and 16, 2014, 2 behaviors on 9/4/14, with interventions which indicated , redirect, 1:1, gave fluids, and backrub, with outcome indicating "0"unchanged. Behaviors on 9/5/14 indicated 3 behaviors of anxiety, restlessness, with interventions which indicated redirect, 1:1, and changed position and outcome indicated no change. Two Behaviors were recorded on 9/11 and 9/14/14 with interventions listed, and no change for outcome.</p>			

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	<p>There was no documentation on evenings and only one entry on nights for 9/16/14, which indicated no behavior.</p> <p>Review of nurse's notes between 9/1 - 9/14/14, indicated the following: 9/6/14 11:00 - 7:00 A.M. shift - "Resident yelling and stated she was in pain, pain medication given with good results;" 9/8/14 untimed - "the resident was agitated and complained of pain to her feet and legs, medication for pain given with relief;" 9/11/14 3:00 - 11:00 P.M. shift - "The resident attempted to get through therapy doors ;" 9/14/14 - 1300 - "The resident was yelling out non-sensical words, and stated she would start throwing things if we don't get these bugs out of here. One on one attention given and the resident was able to speak softly and appropriately for 30 minutes, then again yelled out inappropriate words. Snack offered, fluids, and repositioned. The resident yelled louder when asked if she wanted to lay down, then sitting in her wheelchair at the nurse's station." 9/14/14 3:00 - 11:00 P.M. shift - "The resident was in wheelchair, yelling and shouting. Attempted to re-direct several times, continued to shout out, denies pain."</p>			

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	<p>Review of a social service review note, dated 8/7/14, indicated the resident was confused, had short and long term memory impairment, seemed more anxious, was having trouble sleeping at night, had diagnoses of atypical psychosis and dementia, and the family reported the resident had a history of paranoia before her hospitalization and decline in cognition. The note further indicated the resident seemed to be coming out of anesthesia, and was becoming more alert.</p> <p>The Social Service Director was interviewed, on 9/17/14, at 11:32 A.M., and indicated the resident had physician orders for Seroquel when she was admitted to the facility in June. She indicated she had been "out of it" from the anesthesia due to surgery, and as she became more alert, became restless, and more anxious.</p> <p>The Social Service Director indicated she would review the behavior notes to see why the resident was placed on Seroquel on 8/5/14, and why it was increased on 8/19/14.</p> <p>The Behavior Health Manager was interviewed, on 9/17/14, at 12:04 P.M., and indicated the resident was on Seroquel when admitted, it was discontinued on 7/1/14, and the Nurse</p>			

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	<p>Practitioner (NP) from the psychiatric group re-started the Seroquel 25 milligrams in August, and it was increased to 50 milligrams on August 19, 2014.</p> <p>She indicated the behavior intervention flow records were started on the resident in August, 2014 when she was placed on the Seroquel, and before that, the charting for behaviors would be in the nursing notes. She also indicated behaviors were discussed in the behavior meetings, and the Director of Nursing Services (DNS) kept a book with the behavior meeting minutes. She indicated new medications were discussed daily in the clinical meetings, and staff would report behaviors by documenting on the behavior flow records.</p> <p>The Social Service director provided documentation, on 9/17/14, at 1:35 P.M., from the psychiatric Nurse Practitioner(NP) providing care for the resident. Review of the Behavioral Medicine Evaluation and Management notes from the psychiatric Nurse Practitioner, on 9/17/14, at 2:00 P.M., indicated the following:</p> <p>A note, dated 8/5/14, and signed by the NP, indicated the resident was seen to assess medical and mental status mood and behaviors , and being evaluated for</p>			

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	<p>possible mood stabilizer or change in mood medication. The note indicated the resident had a history of resistance to care, was very confused at times, per staff was paranoid, occasionally saw people in the room, who were not there, and medical history indicated the resident had dementia and unspecified psychosis. The note further indicated the resident had a history of continuous crying, and did not like showers or water on her face. Seroquel 50 milligrams had been discontinued on 7/1/14, and "patient has become more delusional and hallucinating. "</p> <p>The note further indicated, "Patient affect slightly flat. Patient later observed talking to self, so appears to be eperiencing (sic)delusions or hallucinations. "</p> <p>A treatment plan indicated Seroquel 25 milligrams at bedtime for psychoses.</p> <p>A note from the NP, dated 8/11/14, indicated the resident was seen to assess medical and mental status, mood and behaviors, and staff indicated the resident's mood had improved, there was minimal crying, and the resident was more pleasant on approach. The note indicated there were no observed hallucinations or delusions, and no paranoia observed.</p> <p>A note from the NP, dated 8/19/14,</p>			

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	<p>indicated staff reported increased tearfulness, expressed paranoid thoughts, did not want to be alone, did not want to be in bed, did not want to eat, and would open her mouth then refuse food, and oral intake had decreased. The note indicated staff verbalized concerns with appetite or sleep. Also, "No observed hallucinations or delusions" and no paranoia observed. The treatment plan indicated Seroquel was to be increased to 50 milligrams at bedtime.</p> <p>A note from the NP, dated 9/2/14, indicated staff reported mood had improved, minimal crying, more pleasant on approach, and denied concerns with appetite or sleep. Also, no observed hallucinations or delusions, and no paranoia observed.</p> <p>LPN #5 was interviewed on 9/18/14, at 8:50 A.M., and indicated if the resident had a behavior, the nurses were supposed to document the behavior on the behavior logs in the behavior book kept at the nurse's station. She indicated the "O" meant no behavior occurred. She indicated the resident did not like to be messed with, and yelled out more when staff were providing care or the resident had dressing changes.</p> <p>The Administrator provided additional</p>			

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	<p>information, on 9/18/14, at 8:55 A.M. The information was reviewed, on 9/18/14, at 9:10 A.M. A Speech therapy note, dated 8/4/14, indicated due to agitation, the resident was not progressing towards goals. A Behavior meeting log, dated 7/1/14, indicated the resident continued to complain of being tired, some depression, tearful, paranoia waxes and wanes, and the resident was on seroquel, and the medical NP was to evaluate the Seroquel. A Behavior meeting log, dated, 7/15/14, indicated the Seroquel was discontinued and the resident was more alert. A Behavior meeting log, dated 8/19/14, indicated, "crying, paranoid, tries to get oob (out of bed), and the Seroquel was increased to 50 milligrams at bedtime.</p> <p>The Administrator provided the policy for the Behavior Management Program, dated December, 2010, on 9/19/14, at 8:15 A.M. The policy was reviewed, on 9/19/14, at 8:50 A.M., and indicated the following: The Social Worker, or designee, would initiate a behavioral assessment and management plan when staff or the Minimum Data Set (MDS) process identified certain behaviors. The behavioral plan would be placed in the Behavioral Management Program Book.</p>			

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F000356 SS=C	<p>The Assessment would include Identification of behaviors, occurrence of behaviors, and location of behaviors. The behavioral monitoring form /Psychoactive Medications would be kept in the Medication Administration Record (MAR) and nurses were to document each behavior each time it occurred, the intervention used, the precipitating factors, and the outcome of the intervention on the monitoring sheet. Also, it was the responsibility of the clinical manager to insure the nurses were completing the Behavior Monitoring Form correctly.</p> <p>Review of the Nursing Drug Handbook 2014 included the following black box warning for Seroquel: "...drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from C V (cardio-vascular) disease or infection."</p> <p>3.1-48(a)3</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly</p>			

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	<p>responsible for resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to have the current nursing staffing posted on the initial tour of the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 9/15/14 at 8:30 A.M., nursing staff posting was noted at the receptionist desk near the front door of the facility. The staff posting was dated 9/12/14.</p> <p>An interview with the Administrator on</p>	F000356	F356 It is the intent of the facility to display daily staffpostings which are updated at the beginning of each shift with all required information. 1.What corrective actions will be accomplished for those residents found to have been effected by the deficient practice The staffing coordinatorimmediately in-serviced by CEO regarding proper staff posting guidelines. 1.How other residents having the potential to be effected by the same deficient practice will be identified and what corrective action will be taken.	10/10/2014			

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F000371 SS=E	9/19/14 at 11:50 A.M., indicated the staff posting should have been current. The Administrator indicated the staff scheduler was responsible for daily staff posting. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -		No residents were found to be affected by this alleged deficient practice. 1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staffing information is to be completed daily by staffing coordinator. Staffing coordinator will post current staffing daily Monday through Friday and on Friday will post Saturday and Sunday staffing. Receptionist will update staffing sheets on weekend. Staffing coordinator, receptionist and weekend managers have been in-serviced on 9-25-14. 1. How the corrective actions will be monitored to ensure the deficient practice will not recur. Administrator and/or designee will monitor and assure that the staff posting is posted and updated accordingly Monday through Friday and weekend managers will monitor and update weekend staff posting as needed and report to the Administrator or designee every Monday. Results will be reported to the Quality Assurance committee monthly X 3 to assure substantial compliance. 1. The CEO to ensure compliance 10.10.14.		

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	<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> <p>Based on observations, interview, and record reviews, the facility failed to ensure dietary staff washed their hands appropriately and when disposable gloves were removed and new disposable gloves were reapplied.</p> <p>This deficiency affected 79 of 79 residents who received a breakfast tray on 9/15/14 (Dietary Aide #3 and Cook #2).</p> <p>Findings include:</p> <p>On 9/15/14 at 8:15 A.M., during the kitchen tour, Dietary Cook # 2 was observed to open a drawer and remove a pair of tongs with disposable gloves on, then touch her face and lips with the back of her gloves, and with her right hand touched the edge of 4 clean plates, the top of a covered bowl of fruit, and the prepared scrambled eggs without removing her gloves and washing her hands.</p> <p>Dietary aide # 3 left the tray line and opened the door to the walk-in refrigerator touching the door knob and returned to the tray line without washing her hands. Dietary Aide #3 then touched a carton of milk, a cup of juice, an empty</p>	F000371	<p>F371 It is the intent of this facility to store, prepare, distribute and serve food under sanitary conditions.</p> <p>1. What corrective actions will be accomplished for those residents found to have been effected by the deficient practice Dietary cook #2, Dietary Aide #3 and Cook #2 were immediately in-serviced regarding proper and sanity handling of food and food service equipment.</p> <p>1. How other residents having the potential to be effected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>All residents have the potential to be effected. Proper hand-washing and glove usage in-service given by Registered Dietician to all dietary staff on 09.19.2014.</p> <p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Dietician and/or Designee will monitor dietary staff daily to assure proper glove use and hand hygiene on observed. Immediate feedback/ education will be provided if improper use observed as well as Administrator will spot check to</p>	10/10/2014

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	<p>cup, placed those items on a tray and then sent the tray to Cook #2.</p> <p>Cook #2 was observed to leave the tray line, removed her gloves, and did not wash her hands. She then cracked a raw egg on the stove and reapplied a new pair of disposable gloves without washing her hands.</p> <p>On 9/15/14 at 12:00 P.M. in the kitchen the Dietary Aide # 3 was observed to lean her arm on an empty tray and then Dietary Aide #3 placed a carton of milk, a glass of juice and an empty cup on the tray and then sent the tray to Cook #3 who was observed to plate the lunch tray for a resident.</p> <p>On 9/18/14 at 10:00 A.M., an interview with the Registered Dietician who was also the acting Dietary Manager indicated Cook #2 should have washed her hands after she removed the gloves, after touching her face with gloved hands, and after she cracked a raw egg. The Registered Dietician also indicated Dietary Aide #3 should not have been resting with her arm on a tray and Dietary Aide #3 should not have sent the tray through to Cook #2 who had plated a resident's lunch.</p> <p>On 9/18/14 at 11:15 A.M., the 2 policies Proper Handwashing and Proper Wearing</p>		<p>assure compliance twice weekly.</p> <p>1.How the corrective actions will be monitored to ensure the deficient practice will not recur. Results of the observations will bereported to the IDT committee monthly at Quality Assurance meeting monthly ongoing</p> <p>1.The CEO to ensure compliance 10.10.14.</p>				

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F000441 SS=D	<p>Of Gloves In Healthcare dated 01/14 were received from the Administrator and indicated: "Hands must be washed: After working with different food products i.e. raw chicken to fresh fruit..." and "...gloves must be worn when touching any food." "When gloves are used, handwashing must occur...prior to putting on gloves and whenever gloves are changed."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p>			

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	<p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a CNA who had bathed a resident, washed her hands after removing gloves after incontinence care and prior to mouth care. This affected 1 of 3 residents reviewed for Activities of Daily Living. (Resident #59). (CNA #1) The facility also failed to ensure a resident's respiratory equipment was free from potential contamination. This deficiency had the potential to affect 1 of 2 residents reviewed who were receiving oxygen therapy (Resident #84)</p> <p>Findings include:</p>	F000441	<p>F441 It is the intent of the facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>1. What corrective actions will be accomplished for those residents found to have been effected by the deficient practice. CNA # 1 was in-serviced on 9-18-14 on proper hand washing and glove use for Resident #59. Resident # 84 O2 tubing and Nebulizer equipment was changed and placed in a plastic bag on 9-15-14.</p> <p>1. How other residents having the potential to be effected by the same deficient practice will be identified and what corrective</p>	10/10/2014

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	<p>1. CNA #1 was observed bathing Resident #59, in bed, on 9/18/14, at 10 A.M.</p> <p>She washed the resident's upper body, removed a soiled brief, completed incontinence care on the resident, then dressed the resident. The CNA then removed her gloves, but without washing her hands, donned another pair of gloves and proceeded to clean the resident's dentures, which were in a container in the bathroom. After cleaning the dentures, the CNA wiped the inside of the resident's mouth with an oral swab, and attempted to place the dentures in the resident's mouth, however, the resident resisted and indicated she didn't want the dentures placed in her mouth, so the CNA stopped, removed the gloves, and began to position a Hoyer pad under the resident.</p> <p>The Handwashing/Hand Hygiene policy, dated as revised August 2012, was provided by the Administrator, on 9/19/14, at 8:15 A.M.</p> <p>The policy was reviewed, on 9/19/14, at 8:30 A.M., and indicated the following: Employees must wash their hands for at least fifteen seconds using</p>		<p>action will be taken.</p> <p>All residents that require assistance with activities of daily living or utilize respiratory equipment have the potential to be effected by the same deficient practice therefore all Nursing staff will be in-serviced regarding proper hand washing and glove usage by 10.10.14.</p> <p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>All Nursing staff will be in-serviced on proper hand washing and glove usage by 10.10.14. All nursing staff will be in-serviced on care and infection control precautions in storing respiratory tubing not in use by 10.10.14. Any residents that utilize respiratory tubing and are able to be educated will also be educated regarding storage of tubing that they are not currently using or notifying nursing staff that equipment needs to be stored. All respiratory tubing will be placed in plastic bags that are dated and changed weekly.</p> <p>1. How the corrective actions will be monitored to ensure the deficient practice will not recur.</p> <p>Nursing staff will have hand-washing in-service with return demonstration with SDC by 10.10.14. Nurses' Aides will be randomly monitored by Staff Development Coordinator or Designee daily 5 times weekly for</p>	

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	<p>antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after direct resident contact; Before and after assisting a resident with personal care; Before and after assisting a resident with toileting; After removing gloves or aprons. The policy also indicated the use of gloves did not replace handwashing/hand hygiene.</p> <p>2. On 9/16/14 at 11:15 A.M., in Resident 84's room, there was an uncovered oxygen tubing and cannula laying on the floor in front of the resident's wheelchair. Also the resident's nebulizer mask and tubing were on top of the resident's nebulizer machine, uncovered and not secured in a bag.</p> <p>On 9/18/14 at 9:15 A.M. , there was a nebulizer mask and tubing laying on top of the nebulizer machine, not secured in a bag.</p> <p>On 9/18/14 at 2:00 P.M., an interview with LPN #4 indicated the oxygen cannula and tubing should not have been on the floor and the nebulizer mask should have been stored in a bag.</p> <p>The policy titled Oxygen Therapy -</p>		<p>3 weeks and periodically thereafter. DONand/or Designee will monitor respiratory tubing daily to assure that all tubingis placed in plastic bag for protection. Results will be reported to the QA committee monthly ongoing.</p> <p>1.CEO to assure compliance by 10.10.14</p>	

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	Respiratory Care/ Nasal Cannula dated 12/2010 found on the conference room table on 9/18/14 at 12:00 P.M., indicated "The set up and operation of nasal cannula will be the responsibility of Nursing and Respiratory Therapy." All nasal caunulas are to be kept out (sic) of the floor when not in use." 3.1-18(l) 3.1-18(b)(1)						