

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155231	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/15/2012
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NAME OF PROVIDER OR SUPPLIER  RANDOLPH NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaint IN00108190.</p> <p>This visit was done in conjunction with the investigation of Complaint IN00109756.</p> <p>Complaint IN00108190 Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: June 11, 12, 13, 14, and 15, 2012</p> <p>Facility number: 000136 Aim number: 100275450 Provider number: 155231</p> <p>Survey team: Betty Retherford RN TC Karen Lewis RN Ginger McNamee RN</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 11 Medicaid: 46 Other: 16</p>	F0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 07/09/12.</p>	

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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	<p><b>Total: 73</b></p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/20/12 Cathy Emswiller RN</p>				

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F0156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents were informed of possible charges that could be incurred as a result of the lack of Medicare coverage benefits, and the date Medicare services would be discontinued for 2 of 3 residents reviewed who had received notification of Medicare non-coverage. (Resident #'s 14 and 42)</p> <p>Findings include:</p> <p>Review of the "Notice of Medicare Provider Non-Coverage" letters for Resident #'s 14 and 42 on 6/15/12 at 12:50 p.m., indicated the letters lacked information related to a list of items and services with charges for</p>	F0156	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 07/09/12. This facility informs resident orally and in writing of all rules and regulations governing resident conduct and responsibilities during the stay in the facility. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #20 was provided written "Notice of Medicare Provider Non-Coverage" including</p>	07/09/2012

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	<p>non-Medicare residents, what the resident's daily rate would be when Medicare services were discontinued and the date Medicare services would be discontinued.</p> <p>During an interview on 6/15/12 at 1:15 p.m., the Administrator indicated she was not aware it was necessary to have this information listed on the non-coverage letters and would implement that procedure on future letters.</p> <p>3.1-4(a) 3.1-4(f)(3)</p>		<p>appropriate information per regulatory requirements. Resident #14 no longer resides with the facility. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> All residents have the potential to be affected. The "Notice of Medicare Provider Non-Coverage" letter has been reviewed and updated to assure appropriate information per regulatory requirements including available facility items and services with charges for Non-Medicare and written notice provided to appropriate residents. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The "Notice of Medicare Provider Non-Coverage" letter has been reviewed to assure appropriate information per regulatory requirements including available facility items and services with charges for Non-Medicare. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Facility Administrator is responsible and will monitor to assure written "Notice of Medicare Provider Non-Coverage" letter has been</p>		

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			provided to appropriate resident's and assure appropriate information per regulatory requirements including available facility items and services with charges for Non-Medicare. The Administrator will report findings of the "Notice of Medicare Provider Non Coverage" audit quarterly to the facility Quality Assurance Committee. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.	

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was contacted when there was a change in the resident's condition with a possible need to</p>	F0157	It is the practice of this provider to immediately inform the resident, consult with the resident's physician, and if known, notify the residents legal representative or an interested family member	07/09/2012			

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	<p>commence a new treatment for 1 of 3 residents reviewed for nutrition. (Resident #20)</p> <p>Findings include:</p> <p>The clinical record for Resident #20 was reviewed on 6/13/12 at 9:45 a.m..</p> <p>Resident #20's current diagnoses included, but were not limited to, hypertension, diabetes mellitus type 2, chronic renal failure and depression.</p> <p>A physician's order, dated 5/23/12, indicated Resident #20 was to receive a regular, no concentrated sweets diet.</p> <p>Resident #20 had a health care plan, dated 2/27/12, which indicated the resident had a problem listed as, nutritional risk due to a diagnoses of diabetes and necrotic pancreatitis. Interventions for this problem included, monitor weights and intakes, and refer to Registered Dietician and physician for significant weight change.</p> <p>Resident #20's readmission weight was documented on a weight report, as 253.6 pounds for 5/23/12. The</p>		<p>when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # 20's weight was addressed with physician during hospital stay and on 6/22/12 with no new orders, and resident continues to be monitored for weight loss. Licensed nurses were re-educated on the Change of Condition Policy and Procedure on 6/28/12. The Interdisciplinary Team (referred to as IDT) continues to monitor the 24 Hour Report Sheet and Physician Order Forms for resident change of condition. . <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents who experience a change of condition have the potential to be affected by the alleged deficient practice. Licensed nurses were re-educated to the facility Change of Condition Policy and Procedure on 6/28/12, by the Director of Nursing. <b>What measures will be</b></p>				

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	<p>resident's weight , dated 6/5/12, was verbally provided by the Administrator as 218 pounds. The Administrator did not indicate whether this was a loss or a gain in the resident's weight. This was a significant weight loss of 35.6 pounds in 13 days.</p> <p>The May 2012 "Dietary Intake Record" indicated the resident had consumed 25 - 75 % of his daily meals.</p> <p>The clinical record lacked any information to indicate the physician was notified of the weight loss on 6/5/12. The nursing note entries dated 6/5/12 were not related to the resident's weight or weight loss. The dietary progress notes lacked any entry for 6/5/12. The clinical record lacked any information to indicate any interventions were implemented to address the resident's weight loss on 6/5/12.</p> <p>During an interview with the Administrator on 6/14/12 at 3:17 p.m., additional information was requested related to a re-weigh and/or physician notification related to Resident's #20 weight loss.</p> <p>The facility failed to provide any additional information as of exit on</p>		<p><b>put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>Resident status change is placed on the "24 Hour Change of Condition Report Sheet" and the resident will have a documented assessment every shift until the resident's condition stabilizes. The "Physician Order" form is utilized for physician orders or changes in resident status that require a change in the resident's plan of care. The interdisciplinary team will review the "24 Hour Change of Condition Report" and "Physician Order" forms for physician and family notification at the clinical Meeting. The interdisciplinary team determines if any further interventions or changes to the plan of care is necessitated. The Director of Nursing, or designee, will ensure implementation. Charge nurses will review the Medication/Treatment Administration Records during shift report to ensure that medications/treatments are given and documented and that physicians are notified of a resident change of condition.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The physician orders and the 24 Hour Change of Condition Report sheets are</p>				

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	<p>6/15/12.</p> <p>Review of the current facility policy, dated 1/20/12, titled "CHANGE OF CONDITION", provided by the Director of Nursing on 6/14/12 at 1:40 p.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>Ensure appropriate care and documentation occurs when residents experience a change of condition.</p> <p>Procedure:...</p> <p>...3. Notify attending physician promptly of condition change....</p> <p>...6. Document symptoms, assessment, treatment, notifications, etc. in clinical record...."</p> <p>3.1-5(a)(2)</p>		<p>reviewed by the Director of Nursing or designee, to ensure resident change of condition is reported to the physician. A "Change of Condition" Audit tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor the Medication/Treatment Administration Records for compliance with administration, documentation, and physician notification, if applicable. The audits are reviewed by the IDT committee and action plans are developed, as needed, to improve performance. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.</p>		

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F0246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interview and record review, the facility failed to allow residents to get up at the time they were accustomed to prior to entrance to the facility for 2 of 16 residents interviewed for choosing the time they get up. (Resident #E and #M)</p> <p>Findings include:</p> <p>1.) During an interview with resident #E on 6/12/12 at 1:05 p.m., with her family present, she indicated the staff come in and say it is time to get up. She indicated she was not given a choice about what time she gets up. She indicated she always slept later prior to admission to the facility and would like to be allowed to sleep in later now.</p> <p>During an interview with the Administrator and the Director of Nursing on 6/12/12 at 3:30 p.m., they indicated residents were asked what time they liked to go to bed, but not what time they liked to get up. The</p>	F0246	<p>It is the practice of this facility to ensure Residents have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # E and Resident #M were not identified by the Indiana Department of Health survey team. Current resident interviews were conducted and new residents will be assessed upon admission, and no less than annually thereafter to determine preferences related to their daily schedule. Changes will be made to their plan of care according to their preferences. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents residing in the facility have the potential to be affected by the alleged deficient practice Social Service Director</p>	07/09/2012			

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	<p>Director of Nursing indicated the resident was interviewable.</p> <p>Resident #E's clinical record was reviewed on 6/14/12 at 10:00 a.m. The resident had a 3/12/12, quarterly Minimum Data Set assessment. The resident scored 14 out of 15 on her Brief Interview for Mental Status. The score indicated the resident was interviewable.</p> <p>2.) Resident #M was interviewed on 6/11/12 at 12:11 p.m. During the interview, the resident indicated she has to get up when they come in and tell you. She indicated on shower days she is gotten up between 5:00 and 5:30 a.m. She indicated she was accustomed to sleeping in until 8:00 a.m.</p> <p>During an interview with the Administrator and the Director of Nursing on 6/12/12 at 3:30 p.m., they indicated residents were asked what time they liked to go to bed, but not what time they liked to get up. The Director of Nursing indicated the resident was interviewable.</p> <p>3.1-3(v)(1)</p>		<p>was re-educated related to Accommodation of Resident needs. Current resident interviews were conducted and new residents will be assessed upon admission, and no less than annually thereafter to determine preferences related to their daily schedule. Changes will be made to their plan of care according to their preferences. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Residents were interviewed to determine daily routine preferences with changes made to their plan of care according to their preferences. The Social Service form utilized during the assessment process has been amended to include assessment of resident preferences for getting up in the morning. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> A Resident preference interview questionnaire will be utilized with each comprehensive assessment to determine resident preferences related to their daily routine. The audits are reviewed by the IDT committee and action plans are developed, as needed, to improve performance. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as</p>		

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			needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.	

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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 interview and record review, the facility failed to ensure a comprehensive plan of care was developed related to a resident's need for splint application needed due to a contracture of the left thumb for 1 of 3 residents reviewed of the 14 who met the criteria for range of motion review. (Resident #F)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #F was reviewed on 6/13/12 at 2:50 p.m.</p>	F0279	<p>It is the practice of this facility to use the results of the assessments to develop, review and revise the resident's comprehensive plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # F was not identified by the Indiana Department of Health survey team. Residents were assessed by Therapy to determine the need for Restorative Nursing Programs. <b>How will you identify other residents having the potential to be affected by the</b></p>	07/09/2012	

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	<p>Diagnoses for Resident #F included, but were not limited to, history of cerebral vascular accident with left sided weakness and hemiparesis, osteoarthritis, and diabetes mellitus.</p> <p>The clinical record for Resident #F indicated the resident received Occupational Therapy (OT) in March of 2012 for an evaluation of positioning in a chair and weakness of the upper extremities. An OT discharge summary, dated 3/26/12 indicated the resident was being discharged from therapy services due to reaching her optimal functional level. The summary indicated she would continue in a "Restorative Nursing Program for PROM [passive range of motion exercises], all joints in all planes and splintwear." The summary indicated staff education had been completed and the staff were able to complete a return demonstration.</p> <p>A physician's order, dated 3/26/12, indicated the resident had been discontinued from OT and "referred to RNP [restorative nursing program] for PROM and splinting".</p> <p>A "Restorative Nursing Program Communication Form" completed by</p>		<p><b>same deficient practice and what corrective action will be taken?</b> Residents have the potential to be affected by alleged deficient practice. Licensed nurses were re-educated on comprehensive care plans by the Director of Nursing Services and/or designee. Therapy was re-educated on education requirements related to the Restorative Nursing program by the Therapy Manager by 6/28/12.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Licensed nurses were re-educated on the comprehensive care plans by the Director of Nursing Services and/or designee by 6/28/12 MDS coordinator will monitor for comprehensive care plan completions and accuracy. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> A Restorative Nursing Program Audit tool will be utilized Weekly X's 4; Monthly X's 2 and Quarterly thereafter to ensure compliance. The audits are reviewed by the IDT committee and action plans are developed, as needed, to improve performance. The IDT/Quality assurance committee will meet no less than quarterly</p>		

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	<p>the Occupational Therapist, dated 3/26/12, indicated the resident had decreased ROM in her bilateral upper extremities (BUE). Precautions listed on the form were "contractures, pain, skin integrity." The restorative program goals were:</p> <p>"1. BUE PROM all joints in all planes 10 times daily (6-7 times a week). 2. Splint applied daily for 2-4 hours. 3. Skin check completed following removal of splint."</p> <p>The clinical record lacked any physician's orders for the application of the splint for 2-4 hours daily as noted above. The clinical record lacked documentation of any restorative ROME (range of motion exercises) having been completed. The clinical record lacked any information related to where the splint was to be applied, the time schedules for application of the splint, or documentation of the splints having been applied.</p> <p>A health care plan problem, dated 4/4/12, indicated the resident had a risk for skin breakdown related to multiple health problems including the need for a splint. The health care plan problem did not indicate where the splint was to be applied or for how</p>		and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.				

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	<p>long the splint was to be worn.</p> <p>During an interview with the DoN on 6/15/12 at 10:00 a.m., additional information was requested related to the lack of any comprehensive health care plan having been created related to the resident's need for splinting.</p> <p>During an interview on 6/15/12 at 12:00 p.m., the DoN indicated she had no information to provide related to any comprehensive health care plan having been developed identifying where the splint was to be applied and/or for how long it was to be applied.</p> <p>During an interview with the Certified Occupational Therapy Assistant (COTA) on 6/15/12 at 12:40 p.m., additional information was requested related to the location to which Resident #F's splint was to be applied and if any decline in the resident's condition had been noted related to the lack of splinting. She indicated the OT was not present in the facility, but she would review the OT records for Resident #F to obtain the requested information.</p> <p>During an interview on 6/15/12 at 1:30 p.m., the COTA indicated she had checked the resident and had</p>			

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	<p>reviewed the OT records for Resident #F. She indicated the splint was to be applied to the resident's left hand/arm for 2-4 hours daily. She indicated the splint had been created to prevent worsening of a contracture in the resident's left thumb. She indicated the splint would only fit if applied to the left hand/arm. She indicated she had not identified any noticeable decline in the contracture and the splint still fit the resident. She indicated she would provide repeat caregiver education related to the application of the splint.</p> <p>The clinical record lacked any comprehensive health care plan for a contracture of the resident's left thumb requiring the need for a splint.</p> <p>3.1-35(a)</p>			

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F0309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the nursing staff assessed a resident after a large bruised area was noted (Resident #F), failed to obtain and provide timely treatment to a skin tear (Resident #C), failed to transfer a resident in a manner to prevent discomfort (Resident #E) and failed to ensure a resident was re-evaluated for a possible diet change after his dentures were repaired and returned to the facility (Resident #D).</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #F was reviewed on 6/13/12 at 2:50 p.m.</p> <p>Diagnoses for Resident #F included, but were not limited to, history of cerebral vascular accident (stroke) with left sided weakness and hemiparesis, osteoarthritis, and</p>	F0309	<p>It is the practice of this provider to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # F was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents receive follow up documentation related to any change in resident's status. Resident # C was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents receive follow up related to skin tears or any change in resident's status. Resident # E was not identified by the Indiana Department of Health survey team, however, the facility ensures that residents are transferred utilizing a gait belt</p>	07/09/2012	

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	<p>diabetes mellitus.</p> <p>The April 2012 recapitulation of physician's orders for Resident #F indicated "May use Hoyer lift as needed for transfers for safety." The original date of this order was 8/25/10. The orders also indicated the resident received Coumadin (a medication given to thin the blood) 2.5 milligrams daily. The original date of the Coumadin order was 12/29/11.</p> <p>The clinical record indicated the resident had a PT/INR (a test completed to monitor the thinness of the resident's blood) completed on 5/1/12. The lab report indicated the resident's INR level was 2.5. This is within the normal therapeutic range of 2.0 to 3.5 and the physician did not change the resident's Coumadin dose.</p> <p>A health care plan problem, with a "team conference date" of 4/18/12, indicated the resident was a risk for falls related to "impaired mobility and cognition due to hemiparesis and dementia." One of the approaches for this problem was "Hoyer lift for transfers."</p> <p>A Investigation Report, dated 5/5/12, indicated an investigation has been</p>		<p>when a mechanical lift is not utilized. Resident # D was not identified by the Indiana Department of Health survey team, however, the facility ensures that residents that receive dentures are re-evaluated after the receipt of new dentures to ensure a proper diet is obtained. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents who have a change in health status have the potential to be affected by the alleged deficient practice. Residents who are transferred without the use of a mechanical lift have the potential to be affected by the alleged deficient practice. Licensed nurses were re-educated to documentation with changes in status by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed. Licensed nurses, were re-educated to follow up, with changes in status by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed. Licensed nurses and Nursing Assistants were re-educated to the gait belt policy by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed. <b>What measures will be put into place or what systemic changes you will make to ensure that the</b></p>		

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	<p>initiated on 5/5/12 at 5:15 p.m. related to the staff noting a 9 cm by 8 cm yellow discolored area on the center of the Resident #F's chest. The report indicated the resident was on Coumadin (a blood thinner). The investigation indicated the area was probably the result of the Hoyer lift pad pinching the resident's left breast. Witnesses were identified as CNA #2 and CNA #3. The type of injury was described as "hematoma". The form indicated the resident's daughter and physician had been called.</p> <p>The nursing notes lacked any information related to a bruised area being noted on the resident's chest on 5/5/12. There were no nursing notes dated May 5, 6, 7, or 8, 2012. The clinical record lacked any follow up assessments or monitoring related to the area found on 5/5/12.</p> <p>A nursing note entry, dated 5/9/12 at 10:00 a.m., indicated the nursing staff had been called to the resident's room by "rehab". The note indicated the left side of the resident's chest area was swollen and hard to palpitation. The note indicated the physician was contacted and an order obtained for a PT/INR blood test.</p> <p>The PT/INR report, dated 5/9/12,</p>		<p><b>deficient practice does not recur?</b> Licensed nurses were re-educated on the change of condition 24 hour report sheet by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed. The Director of Nursing Services is responsible to monitor for facility compliance in providing necessary care and services to the residents. Licensed nurses and Nursing Assistants were re-educated to the gait belt policy by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The physician orders and the 24 Hour Change of Condition Report sheets are reviewed by the Director of Nursing or designee, weekly X's 4, monthly X's 2, and Quarterly thereafter to monitor for the need for change of condition, to ensure resident change of condition is reported to the physician. An ancillary service follow up log will be utilized by Social Services weekly X's 4, Monthly X's 2, and Quarterly thereafter to monitor for the need for ancillary services follow up. A "Changer of Condition" Audit tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor the Medication/Treatment Administration Records for</p>				

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	<p>indicated the resident's INR level was 4.2. This indicated the resident's blood was too thin and above the therapeutic level. The physician was contacted and an order was obtained to hold the resident's Coumadin for 2 days and recheck the PT/INR blood test on 5/12/12.</p> <p>During an interview with the DoN on 6/14/12 at 10:39 a.m., additional information was requested related to the lack of documentation of the bruised area in the nursing notes when found on 5/5/12 and the lack of follow-up monitoring and assessment related to the injury.</p> <p>On 6/14/12 at 1:40 p.m., the DoN provided some 24 hour report sheets documenting some information related to Resident #F. These reports were not part of the clinical record. No information dated 5/5 (the date of the occurrence) or 5/6 was provided. A 24 hour report sheet, dated 5/7/12, indicated the area on the resident's left chest remained yellow in color. No vital signs were present. A 24 hour report sheet, dated 5/8/12, indicated the bruise on the resident's chest was fading and contained several sets of vitals signs. The size of the bruising and/or firmness of the area was never monitored in the</p>		<p>compliance with administration, documentation, and physician notification, if applicable. The audits are reviewed by the IDT committee and action plans are developed, as needed, to improve performance. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.</p>				

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	<p>clinical record prior to the entry made on 5/9/12.</p> <p>During an observation and interview on 6/15/12 at 11:50 a.m., the resident's daughter indicated she had been notified of the resident's bruise prior to the area becoming swollen and hard to touch. The daughter opened the resident's blouse slightly and indicated the area was still hard to touch. A slight yellowish discoloration was still noticeable on the left side of the resident's chest.</p> <p>2.) The clinical record for Resident #C was reviewed on 6/13/12 at 9:44 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, dementia with behaviors and neurodermatitis.</p> <p>A health care plan problem, last reviewed on 5/18/12, indicated Resident #C was at risk for skin breakdown due to incontinence, picking at his skin, and problems with improper body alignment. Approaches for this problem included, but were not limited to, "observe skin with daily activities of daily living care for signs of breakdown or irritation" and "record any finding in nursing notes, weekly skin log/ulcer report</p>			

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	<p>and report to medical doctor for appropriate treatment."</p> <p>A nursing note, dated 5/28/12 at 10 a.m., indicated a "skin tear" had been noted on the resident's left forearm. The area was described as a 1 cm by 2 cm skin tear. The nursing note indicated the area was cleansed with normal saline and the physician had been "faxed" related to the skin tear being found.</p> <p>The next nursing note was dated 5/31/12 at 3:00 p.m. The note indicated new orders had been received for Resident #C.</p> <p>A physician's order, dated 5/31/12, indicated a treatment had been ordered for the skin tear on the resident's left forearm. The order was "cleanse with NS (normal saline), [apply] triple antibiotic ointment cream and cover with suresite [a clear thin dressing] - change every 3 days".</p> <p>The clinical record lacked any assessment and/or monitoring of the resident's skin tear from the time it was found on 5/31/12 and the date the order was obtained on 5/31/12. The clinical record lacked documentation of any other contact with the physician other than the fax</p>				

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	<p>sent on 5/28/12 prior to the order being obtained on 5/31/12.</p> <p>This indicated a time period of 3 days from the date the skin tear was noted and a treatment order was obtained.</p> <p>The May 2012 lacked any documentation of the treatment being completed on 5/31/12.</p> <p>The June 2012 treatment administration record (TAR) for Resident #C from 6/1/12 through 6/12/12 indicated the treatment was first completed on 6/2/12. This indicated a time period of two days from the day the order was obtained and a treatment done and a time period of 5 days from the date the skin tear was found and the first treatment was completed.</p> <p>The June TAR indicated the treatment was done on the following days: June 2, 2012 (the first treatment-two days after the order was obtained) June 5, 2012 June 10, 2012 (a time period of 5 days between treatments)</p> <p>The June TAR indicated the treatment was not done on 6/8/12 which would have been the three day</p>			

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	<p>time period from the June 5th treatment.</p> <p>During an interview with the Administrator and DoN on 6/13/12 at 10:30 a.m., additional information was requested related to the lack of assessment and follow up of the wound after the physician was faxed. Additional information was requested related to the delay in starting the treatment and the 5 day gap between the June 5th treatment and the June 10th treatment.</p> <p>During an interview on 6/15/12 at 1:45 p.m., the DoN indicated she had no information to provide related to monitoring of the skin tear after it was noted on 5/28/12 and a treatment was obtained on 5/31/12. She indicated no wound monitoring records had been developed related to the skin tear. She indicated she had no information to provide related to the delay in starting the treatments or the five day gap between treatments.</p> <p>3.) During an interview with resident #E on 6/12/12 at 1:05 p.m., with her family present, she indicated the staff frequently do not use a gait belt to transfer her. She said they go under her arms to transfer her and it hurts her. The family indicated they have observed the staff transferring her this</p>				

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	<p>manner as well. The family indicated the wheelchair is placed across from the chair Resident #E is being transferred from and is pivoted 180 degrees. The resident said she feels like she is plopped into the wheelchair when she is transferred in this manner and it hurts.</p> <p>During an interview with the Administrator and the Director of Nursing on 6/12/12 at 3:30 p.m. The Director of Nursing indicated the resident was interviewable and a gait belt was to be used when transferring the resident. She indicated some staff can transfer the resident with one assist and some staff requires two assist. She indicated it was up to the staff to decided how the resident is to be transferred.</p> <p>The CNA Assignment Sheet for Resident #E was provided on 6/12/12 at 3:30 p.m., by the Director of Nursing. The sheet indicated the resident had right sided weakness and was paralyzed on the left side. The sheet indicated the resident required one or two assists with a gait belt for transfers.</p> <p>Resident #E's clinical record was reviewed on 6/14/12 at 10:00 a.m. The resident had a 3/12/12, quarterly</p>			

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	<p>Minimum Data Set assessment. The resident scored 14 out of 15 on her Brief Interview for Mental Status. The score indicated the resident was interviewable. The assessment indicated the resident required extensive assistance of one transfers.</p> <p>Review of the 7/98, "Indiana State Department of Health Core Curriculum" for assist to chair indicated the chair is to be placed on the resident's unaffected side.</p> <p>4.) The clinical record for Resident #D was reviewed on 6/13/12 at 1:00 p.m.</p> <p>Diagnoses for Resident #D included, but were not limited to, anxiety, depression, Alzheimer's dementia, and diabetes mellitus type 2.</p> <p>A Social Service progress note, dated 4/30/12, indicated resident had been seen by the in-house dentist and his dentures had been sent out for repair.</p> <p>A telephone order, dated 5/2/12, indicated the resident was to have a mechanical soft diet and ground meat until dentures repaired.</p> <p>The clinical record lacked any information related to the</p>			

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	<p>re-evaluation of the resident's diet after his dentures were repaired and returned to facility.</p> <p>During an interview with the Administrator, Director of Nursing and the RN Consultant on 6/13/12 at 3:55 p.m., information regarding resident's dentures was requested.</p> <p>During an interview with the Administrator on 6/14/12 at 9:05 a.m., she indicated the resident's dentures were repaired and returned to the facility on 5/8/12. She indicated speech therapy was supposed to evaluate the resident with dentures in place. A copy of the speech evaluation was requested.</p> <p>During an interview with the Administrator on 6/14/12 at 9:25 a.m., she indicated she could not find a speech evaluation for the resident. She indicated the physician had been contacted for an order for a speech evaluation for the resident today.</p> <p>A telephone order, dated 6/14/12, indicated the speech evaluation had been completed for Resident #D and his diet was to be modified to regular consistency.</p> <p>5.) Review of the current facility</p>						

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	<p>policy, dated 1/20/12, titled "CHANGE OF CONDITION", provided by the Director of Nursing on 6/14/12 at 1:40 p.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>Ensure appropriate care and documentation occurs when residents experience a change of condition.</p> <p>Procedure:</p> <p>1. Assess resident's condition: change of movement or range of motion, level of consciousness, pain, swelling, bruising, discoloration, vital signs, respiratory status, neurological checks for injuries such as falls, etc....</p> <p>...3. Notify attending physician promptly of condition change....</p> <p>...5. Communicate condition change on the 24 hour report.</p> <p>6. Document symptoms, assessment, treatment, notifications, etc. in clinical record.</p> <p>7. Follow up nursing assessments and monitoring continue until condition has stabilized or at least 72 hours. Assess signs and symptoms</p>				

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	<p>related to change in condition at least one time every 8 hours-12 hours and more often if symptomatic...</p> <p>...9. Examples of significant change include but are not limited to the following:...</p> <p>...B. Occurrence of:...</p> <p>...e). Bruises, laceration, blisters, rashes, or skin tears, swelling or discoloration...."</p> <p>3.1-37(a)</p>			

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F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, record review, and interview, the facility failed to ensure restorative range of motion exercises and splinting services were provided for 1 of 3 residents reviewed of the 14 who met the criteria for range of motion review. (Resident #F)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #F was reviewed on 6/13/12 at 2:50 p.m.</p> <p>Diagnoses for Resident #F included, but were not limited to, history of cerebral vascular accident with left sided weakness and hemiparesis, osteoarthritis, and diabetes mellitus.</p> <p>The clinical record for Resident #F indicated the resident received Occupational Therapy (OT) in March of 2012 for an evaluation of positioning in a chair and weakness of the upper extremities. An OT discharge summary, dated 3/26/12</p>	F0318	<p>It is the practice of this facility to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #F was not identified by the Indiana Department of Health survey team; however splints are being applied per physician order. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents with a limited range of motion have the potential to be affected by the alleged deficient practice. Nursing staff were re-educated on following a resident's plan of care, including application of splints on 6/28/12, and ongoing. Therapy was re-educated on education requirements related to the Restorative Nursing program by the Therapy Manager by 6/28/12. <b>What measures will be</b></p>	07/09/2012			

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	<p>indicated the resident was being discharged from therapy services due to reaching her optimal functional level. The summary indicated she would continue in a "Restorative Nursing Program for PROM [passive range of motion exercises], all joints in all planes and splintwear." The summary indicated staff education had been completed and the staff were able to complete a return demonstration.</p> <p>A physician's order, dated 3/26/12, indicated the resident had been discontinued from OT and "referred to RNP [restorative nursing program] for PROM and splinting".</p> <p>A "Restorative Nursing Program Communication Form" completed by the Occupational Therapist, dated 3/26/12, indicated the resident had decreased ROM in her bilateral upper extremities (BUE). Precautions listed on the form were "contractures, pain, skin integrity." The restorative program goals were:</p> <p>"1. BUE PROM all joints in all planes 10 times daily (6-7 times a week). 2. Splint applied daily for 2-4 hours. 3. Skin check completed following removal of splint."</p>		<p><b>put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Nursing staff were re-educated on following a resident's plan of care, including application of splints on 6/28/12, and ongoing. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> A Restorative Nursing IDT tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter, to monitor splint application. The governing IDT committee will review the data. If the threshold for compliance is not met, an action plan will be developed. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.</p>	

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	<p>The clinical record lacked any physician's orders for the application of the splint as noted above. The clinical record lacked documentation of any restorative ROME (range of motion exercises) having been completed. The clinical record lacked any information related to where the splint was to be applied, the time schedules for application of the splint, or documentation of the splints having been applied.</p> <p>The CNA assignment sheets for Resident #F, provided by the Assistant Director of Nursing on 6/15/12 at 10:00 a.m., lacked any information related to the resident receiving restorative ROME and/or splints to any extremity.</p> <p>During observation on 6/13/12 at 2:30 p.m., Resident #F was resting in bed and was not wearing any splints. During an observation on 6/14/12 at 11:25 a.m., the resident was up in her reclining geri chair and was not wearing any splints. Her left had was noted to be curled inward. No hand roll or splint device was in place.</p> <p>During an interview with the DoN on 6/15/12 at 10:00 a.m., additional information was requested related to the lack of documentation of any</p>						

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	<p>restorative ROME and splinting having been completed for Resident #F. The DoN indicated she thought the splint was being applied to the right arm, but she would have to check.</p> <p>During an interview on 6/15/12 at 12:00 p.m., the DoN indicated she had no information to provide related to any restorative services and/or splinting had been given to Resident #F since her OT was discontinued on 3/26/12. She indicated the resident would have received routine ROME by the CNAs during A.M. and P.M. care, but that would not be documented other than routine care.</p> <p>During an interview with the Certified Occupational Therapy Assistant (COTA) on 6/15/12 at 12:40 p.m., additional information was requested related to the location to which a splint was to be applied and if any decline in the resident's condition had been noted. She indicated the OT was not present in the facility, but she would review the OT records for Resident #F to obtain the requested information.</p> <p>During an interview on 6/15/12 at 1:30 p.m., the COTA indicated she had checked the resident and had</p>				

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	<p>reviewed the OT records for Resident #F. She indicated the splint was to be applied to the resident's left hand/arm for 2-4 hours daily. She indicated the splint had been created to prevent worsening of a contracture in the residents left thumb. She indicated the splint would only fit if applied to the left hand/arm. She indicated she had not identified any noticeable decline in the contracture and the splint still fit the resident. She indicated she would provide repeat caregiver education related to the application of the splint.</p> <p>2.) Review of the current facility policy, undated, titled "Managing Splints and Braces", provided by the Director of Nursing on 6/15/12 at 2:46 p.m., included, but was not limited to, the following:</p> <p>"Goals</p> <p>The goals of wearing splints and/or braces are to:</p> <p>Maintain the resident's range of motion (ROM)</p> <p>Support or protect weak muscles and/or damaged joints during functional activities</p> <p>The goals of the section are to:</p> <p>Ensure splints and braces are</p>			

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	<p>applied properly</p> <p>Identify problems with the splint or brace that may result in any of the following for the resident:...</p> <p>...Contractures Loss of function</p> <p>Initial Instructions</p> <p>Before beginning to use splints or braces with a resident, you should know the following things:...</p> <p>...When should the splint or brace be used? During activities or at rest; in bed or while up in a wheelchair; throughout the day or only during certain times?...</p> <p>...Documentation</p> <p>1. Document the splint or brace that was applied, and the time it was left in place....</p> <p>...3. Document any resident complaints while wearing the splint, such as pain, numbness, coldness of extremities, etc...."</p> <p>Ensure appropriate care and documentation occurs when residents experience a change of condition.</p>			

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	<p>Procedure:</p> <p>1. Assess resident's condition: change of movement or range of motion, level of consciousness, pain, swelling, bruising, discoloration, vital signs, respiratory status, neurological checks for injuries such as falls, etc....</p> <p>...3. Notify attending physician promptly of condition change....</p> <p>...5. Communicate condition change on the 24 hour report.</p> <p>3.1-42(a)(2)</p>				

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F0323 SS=D	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure fall risk assessments were completed accurately (Resident #D) and failed to ensure each resident received the proper assistance and supervision to complete a Hoyer lift transfer in a manner to ensure resident safety (Resident #F) for 2 of 6 resident's reviewed who met the criteria for falls.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #F was reviewed on 6/13/12 at 2:50 p.m.</p> <p>Diagnoses for Resident #F included, but were not limited to, history of cerebral vascular accident with left sided weakness and hemiparesis, osteoarthritis, and diabetes mellitus.</p> <p>The April 2012 recapitulation of physician's orders for Resident #F indicated "May use Hoyer lift as needed for transfers for safety." The original date of this order was</p>	F0323	<p>It is the practice of this provider to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # D was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents are assessed accurately for fall risk. Resident # F was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents receive proper assistance and supervision to complete hoyer lift transfers. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents at risk to fall and residents requiring a hoyer lift for transfers have the potential to be affected by the alleged deficient practice. Licensed nurses were re-educated on the fall risk assessments on 6/21/12 and 6/28/12 and ongoing. Certified nursing assistants were</p>	07/09/2012

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	<p>8/25/10.</p> <p>A health care plan problem, with a "team conference date" of 4/18/12, indicated the resident was a risk for falls related to "impaired mobility and cognition due to hemiparesis and dementia." One of the approaches for this problem was "Hoyer lift for transfers."</p> <p>During an interview with the DoN on 6/14/12 at 1:40 p.m., the DoN indicated it was facility policy for two nursing staff to be present during Hoyer lift transfers to provide proper positioning and ensure resident safety.</p> <p>A Investigation Report, dated 5/5/12, indicated an investigation has been initiated on 5/5/12 at 5:15 p.m. related to the staff noting a 9 cm by 8 cm yellow discolored area on the center of the Resident #F's chest. The report indicated the resident was on Coumadin (a blood thinner). The investigation indicated the area was probably the result of the Hoyer lift pad pinching the resident's left breast. Witnesses were identified as CNA #2 and CNA #3. The type of injury was described as "hematoma". The form indicated the resident's daughter and physician had been called.</p>		<p>re-educated on transfer procedures on 6/21/12 and 6/28/12 and ongoing. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Residents are assessed for fall risk upon admission/re-admission and no less than quarterly. The charge nurse implements appropriate interventions to prevent falls. Those residents at high risk are reviewed by the Interdisciplinary Team for the least restrictive assistance device to prevent injury. The resident's plan of care and resident care sheets are revised, as needed. The Interdisciplinary Team reviewed residents fall risk score with each fall to ensure an appropriate change in the plan of care is initiated. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> Residents with falls will be reviewed for accurate assessments by the IDT with each event, to monitor compliance. The governing CQI committee will review the data. If the threshold for compliance is not met, an action plan will be developed. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly</p>		

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	<p>A "Witness Statement" made by the DoN, dated 5/6/12 at 4:15 P.M., indicated she was notified of the bruising on Resident #F and it was on her left breast in the middle of the breast. "I instructed the staff working at that time to ensure the Hoyer pad was positioned correctly during transfers".</p> <p>During an interview on 6/14/12 at 10:39 a.m., the DoN indicated she had completed the investigation related to the bruising noted on 5/5/12 on Resident #F's chest. She indicated she had talked to all the staff members working who could possibly have used the lift on 5/5/12 to get Resident #F up that morning and back to bed prior to the bruising being noted on her chest. She indicated no staff members would identify themselves as the ones who had transferred the resident and/or assisted with the transfer on that date. She identified CNA #4 as the CNA she felt had gotten Resident #F up on that date. She indicated CNA #4 no longer worked at the facility. She indicated she did not know if the resident's transfers had been completed with one or two CNA's or if the lift pad had been properly placed to help prevent the resident from</p>		X's 2, and quarterly for 6 months.				

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	<p>being pinched during a transfer.</p> <p>2.) The clinical record for Resident #D was reviewed on 6/13/12 at 1:00 p.m.</p> <p>Diagnoses for Resident #D included, but were not limited to, anxiety, Alzheimer's dementia, diabetes mellitus type 2, stroke, and depression.</p> <p>The clinical record indicated Resident #D fell on 1/30/12, 2/9/12, 3/17/12, 4/7/12, 5/2/12, 5/5/12, and 6/4/12.</p> <p>The clinical record indicated the Fall Risk Assessments on 2/14/12, 3/4/12, and 4/30/12 were completed incorrectly. The "History of Falls" sections on the assessment form were scored incorrectly. The scoring on the form reflected no falls or a lesser amount of falls than actually occurred. The correct scoring would have represented "High Risk" for the resident for falls.</p> <p>Review of the current facility policy, dated 1/22/12, titled "FALL PREVENTION", provided by the Administrator on 6/14/12 at 3:435 p.m., included, but was not limited to, the following:</p> <p>"Purpose:</p>			

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	<p>Identify residents at risk for falls and reduce risk of falls and/or injury.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>Each resident will have a fall risk assessment performed by a licensed nurse upon admission, quarterly, annually, and upon a significant change.</li> <li>Residents identified as a fall risk will be placed on a fall prevention program...."</li> </ol> <p>3.1-45(a)(2)</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure heart rates were obtained prior to administration of medications which could need to be withheld based on the pulse rate for 1 of 10 residents reviewed for unnecessary medications. (Resident #L)</p> <p>Findings include:</p> <p>Resident #L's clinical record was review on 6/13/12 at 9:55 a.m. The</p>	F0329	<p>It is the practice of this facility to ensure that each residents drug regimen remain free from unnecessary drugs without adequate monitoring. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # L was not identified by the Indiana Department of Health survey team; however, the facility ensures that resident's medications are monitored per physician's orders. <b>How will you</b></p>	07/09/2012

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	<p>resident's diagnoses included, but were not limited to, Alzheimer's dementia, bradycardia, and hypertension.</p> <p>The resident's current Physician's Orders were signed and dated by the Physician on 4/4/12. There was an order for metoprolol succinate [a blood pressure medication] 25 milligram tablet give 1/2 tablet [12.5 milligram] orally two times a day - hold for blood pressure less than 110 or heart rate less than 60. The order did not indicate if the medication was to be held for systolic or diastolic blood pressure of less than 110.</p> <p>Review of the June, 2012, Medication Administration Record from 6/1/12 through 6/12/12 indicated the metoprolol succinate medication was given on the following dates and times without any record of the pulse rate having been taken prior to administration of the medication:</p> <p>9:00 a.m. dose-given on 6/4, 6, 9, and 10-no heart rate recorded 8:00 p.m. dose- given on 6/1, 4, 5, 6, 7, 8, 9, 10, and 11-no heart rate recorded</p> <p>This resulted in the medication having been given on 13 occasions without</p>		<p><b>identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents with physician orders for medications requiring monitoring have the potential to be affected by the alleged deficient practice. Licensed nurses were re-educated on medication monitoring by the Director of Nursing on 6/21/12 and 6/28/12 and ongoing. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The facility completed an audit of medications requiring monitoring by 6/14/12, to ensure that all orders have parameters included on the Medication administration record. The nurse receiving a new order including monitoring parameters will assure those parameters are communicated on the MAR. The nurse, completing review of the new MAR before placing into use, will assure parameters are documented on the MAR and appropriate space is allotted for documentation. The Interdisciplinary Team reviews the Physician Order Form(s), and the 24 Hour Report Sheet. The Director of Nursing Services, or designee, is responsible to monitor compliance. <b>How will the corrective action(s) be monitored to ensure the</b></p>		

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	<p>the heart rate being monitored prior to the administration of the medication during the time period noted above.</p> <p>During an interview with the Director of Nursing on 6/14/12 at 9:22 a.m., she indicated the heart rates had not been obtained two times a day as ordered by the physician.</p> <p>3.1-48(a)(3)</p>		<p><b>deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>A MAR/TAR audit tool is utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with medication administration. The audits are reviewed by the IDT committee and action plans are developed, as needed, to improve the environment. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.</p>		

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure sliding scale insulin was administered as ordered by the physician for 1 of 10 residents reviewed for unnecessary medications. (Resident #106)</p> <p>Findings include:</p> <p>The clinical record for Resident #106 was reviewed on 6/14/12 at 2:40 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, insulin dependent diabetes mellitus, Alzheimer's dementia, and hypertension.</p> <p>Admission orders, dated 6/4/12, indicated Resident #106 received Lantus insulin 16 units subcutaneously at bedtime. The orders also indicated the resident was to receive sliding scale insulin coverage based on accucheck results done before or with each meal and at bedtime. The Humalog sliding scale insulin was to be given based on the schedule noted below except the</p>	F0333	<p>It is the practice of this provider to ensure that the facility is free of medication error rates of five percent or greater. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #106's physician was notified and the order was clarified to ensure the resident receives the appropriate dose of insulin. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents who receive medications have the potential to be affected by the alleged deficient practice. Licensed nurses were re-educated on medication administration on 6/21/12, and 6/28/12, and ongoing by the Director of Nursing Services and/or designee. Licensed nurses were re-validated on medication pass by the Director of Nursing and/or designee by 6/29/12, and ongoing. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Licensed nurses were</p>	07/09/2012

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	<p>bedtime coverage was to be half of the listed dose.</p> <p>Blood sugar readings: 100-149-give 4 units of Humalog insulin 150-199-give 6 units of Humalog insulin 200-250-give 8 units of Humalog insulin 251-300-give 10 units of Humalog insulin 301-350-give 14 units of Humalog insulin 351-400-give 18 units of Humalog insulin 401-450-give 20 units of Humalog insulin over 450 page medical doctor</p> <p>This order was transcribed in error on the medication administration record (MAR). The June 2012 MAR indicated the resident was to get half doses for the blood sugar readings taken 3 times a day before or with meals. The MAR indicated the resident was to receive the full dose of sliding scale coverage with the bedtime dose.</p> <p>The MAR indicated the incorrect dose of insulin was given on the following dates and times:</p>		<p>re-educated on Medication Administration on 6/21/12 and 6/28/12, and ongoing by the Director of Nursing Services and/or designee. Licensed nurses were re-validated on medication pass by the Director of Nursing or designee by 6/28/12, and ongoing. The Director of Nursing and/or designee is providing daily observations, on all shifts, with medication administration and documentation with licensed nurses and additional education is provided to those employees who are not 100% compliant, weekly X's 4, monthly X's 2, and quarterly there after. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> A MAR/TAR audit tool will be utilized weekly x 4, monthly, to monitor compliance with medication administration. The governing IDT committee will review the data. If the threshold for compliance is not met, an action plan will be developed. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.</p>		

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	<p>6/6/12 at 11 a.m.- blood sugar 203-4 units given-should have been 8 units</p> <p>6/6/12 at 8 p.m.- blood sugar 230-8 units given-should have been 4 units</p> <p>6/7/12 at 7 a.m.- blood sugar 137-2 units given-should have been 4</p> <p>6/7/12 at 11 a.m.-blood sugar 214-4 units given-should have been 8</p> <p>6/7/12 at 4 p.m.- blood sugar 262-5 units given-should have been 10</p> <p>6/7/12 at 8 p.m.- blood sugar 138-4 units given-should have been 2</p> <p>6/8/12 at 7 a.m.- blood sugar 221-4 units given-should have been 8</p> <p>6/8/12 at 11 a.m.- blood sugar 175-3 units given-should have been 6</p> <p>6/8/12 at 4 p.m.- blood sugar 160-3 units given-should have been 6</p> <p>6/8/12 at 8 p.m.-blood sugar 218-8 units given-should have been 4</p> <p>6/9/12 at 7 a.m.-blood sugar 103-2 units given-should have been 4</p> <p>6/9/12 at 11 a.m.-blood sugar 228-4 units given-should have been 8</p> <p>6/9/12 at 8 p.m.-blood sugar 163-6 units given-should have been 3</p> <p>6/10/12 at 11 a.m.-blood sugar 200-4 units given-should have been 8</p> <p>6/10/12 at 4 p.m.- blood sugar 171-3 units given-should have been 6</p> <p>6/10/12 at 8 p.m.-blood sugar 148-4 units given-should have been 2</p> <p>6/11/12 at 7 a.m.- blood sugar 123-2 units given-should have been 4</p> <p>6/11/12 at 11 a.m.- blood sugar 188-3</p>				

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	<p>units given-should have been 6 6/11/12 at 4 p.m.-blood sugar 158-3 units given- should have been 6 6/11/12 at 8 p.m.- blood sugar 157-6 units given-should have been 3 6/12/12 at 7 a.m.- blood sugar 175-3 units given-should have been 6 6/12/12 at 11 a.m.- blood sugar 226-4 units given-should have been 8 6/12/12 at 4 p.m. - blood sugar 208-4 units given-should have been 8 6/12/12 at 8 p.m.- blood sugar 212-8 units given-should have been 4 6/13/12 at 7 a.m.- blood sugar 148-2 units given-should have been 4 6/13/12 at 11 a.m.- blood sugar 240-4 units given-should have been 8 6/13/12 at 4 p.m.-blood sugar 197- 3 units given-should have been 6 6/13/12 at 8 p.m.- blood sugar 189-6 units given-should have been 3 6/14/12 at 11 a.m.- blood sugar 184-3 units given-should have been 6</p> <p>During an interview with the Administrator and DoN on 6/14/12 at 4:10 p.m., additional information was requested related to the incorrect transcription of the order noted above and the wrong dose of insulin given on the dates noted above.</p> <p>During an interview on 6/15/12 at 9:55 a.m., the Administrator indicated the incorrect dose of insulin had been</p>				

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	<p>given on the dates noted above. She indicated the physician had been notified and the order on the MAR had been clarified and changed to reflect the correct dosage of insulin based on the test results in accordance with the physician's order.</p> <p>3.1-25(b)</p>				

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F0353 SS=C	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on record review and interview, the facility failed to ensure there was always sufficient staff on duty to ensure the needs of the residents were met in a timely manner for 6 of 6 residents (Resident #'s 27, 20, 93, 110, 1 and E) reviewed of the 16 who met the criteria for sufficient nursing staff review and for 2 of 4 family interviews (Resident # 9) related to sufficient staff.</p> <p>Findings include:</p> <p>During a review of the Resident</p>	F0353	It is the practice of this facility to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Licensed Nurses will be utilized to work as C.N.A.'s when a C.N.A. is not available. Managers who hold a Certified Nursing Assistant certificate will be utilized to work as C.N.A.'s when a C.N.A. is not available. <b>How will you identify</b>	07/09/2012			

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	<p>Council minutes from January 2012 through June 2012, they included, but were not limited to, the following:</p> <p>1/10/12 meeting beds aren't being made waiting too long to get up and get them dressed/sitting too long in bathroom staff/CNA's - short</p> <p>2/8/12 meeting. not enough staff-CNA's bed's not being made until early afternoon call lights left unanswered 15-20 minutes</p> <p>3/13/12 meeting staff-short on weekends</p> <p>4/10/12 meeting. beds not made till end of day ice not passed until after 10 a.m.</p> <p>6/12/12 meeting ice passed untimely call lights taken 1 hour to be answered on second shift</p> <p>During resident interviews the following was noted:</p> <p>During an interview with Resident #J on 6/12/12 at 10:08 a.m., she</p>		<p><b>other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents residing in the facility have the potential to be affected by the alleged deficient practice. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The Charge Nurse has a list of employees who have the potential to work as a C.N.A., if coverage is not found Licensed Nurses will be scheduled as C.N.A.'s and will be added to the daily staffing sheets. When alternate coverage is needed managers that hold a C.N.A. license are called to work as a C.N.A. The facility continues recruitment efforts for Certified Nursing Assistants. Resident council concerns regarding adequate staffing will be brought to the attention of the administrator. The administrator and/or designee will ensure resident care needs are met. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> All staffing needs will be called in to the Director of Nursing to ensure that appropriate staff can be identified. The governing IDT committee will review the data. If</p>		

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	<p>indicated that the facility did not have enough aides working on any of the shifts.</p> <p>During an interview with Resident #K on 6/11/12 at 11:45 a.m., he indicated the facility did not have enough staff, especially on the weekends. He indicated he has had to wait over an hour on the bed pan.</p> <p>During an interview with Resident #E on 6/12/12 at 1:29 p.m., she indicated there is a long call light wait. She also indicated that sometimes staff will come in and turn off call light and not come back.</p> <p>During an interview with the family of Resident #L on 6/11/12 at 2:39 p.m., she indicated she asked 30 minutes ago for someone to take her mother to the bathroom and they still have not because it takes two staff to assist her mother.</p> <p>During an interview with Resident #M on 6/11/12 at 12:21 p.m., she indicated the staff frequently complain about other staff not coming in and/or doing their jobs.</p> <p>During an interview with Resident #N on 6/11/12 at 3:18 p.m., she indicated the past Friday she had to wait over</p>		<p>the threshold for compliance is not met, an action plan will be developed. Social service director and/ or designee will conduct interviews with no less than 10 residents weekly X's 4, montly X's 2, and quarterly there after. The IDT/Quality assurance committe will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.</p>				

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	<p>30 minutes and Saturday over 1 hour for her call light to be answered. Her roommate went to get someone but was unable to find anyone to help.</p> <p>During an interview with Resident #G on 6/12/12 at 10:30 a.m., she indicated she did not think the facility had enough staff. She has to wait over half an hour for her call light to be answered once or twice a week. She also indicated staff will come in and turn off the call light and say they will be right back, but don't come back.</p> <p>During an interview with the Administrator on 6/13/12 at 10:00 a.m., information was requested related to the optimal level of staff the facility desired to provide resident care for each shift and unit.</p> <p>During a review of the facility optimal staffing levels on 6/13/12 at 1:00 p.m., provided by the Administrator at that time, the information indicated four CNAs were necessary to provide optimum CNA staffing on the 10 p.m. -6 a.m.</p> <p>During a review of the "as worked" CNA schedules for the time period of 5/1/12 through 6/11/12, conducted with the DoN on 6/15/12 at 1:00 p.m.,</p>			

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	<p>the following was noted:</p> <p>During the month of May 2012, the facility had only 3 CNA's on the 10 p.m. to 6 a.m. shift to provide care to approximately 70 residents for 20 of the 31 days of the month. This indicated they had one less CNA working than the identified optimal level of staff on 20 of 31 night (10 p.m.-6 a.m.) shifts.</p> <p>During the month of June 2012, the facility had only 3 CNA's on the 10 p.m. to 6 a.m. shift to provide care to approximately 70 residents for 5 of the 11 reviewed days of the month. This indicated they had one less CNA working than the identified optimal level of staff on 5 of 11 night (10 p.m.-6 a.m.) shifts.</p> <p>There had been other "call ins" during the months noted above, but the staff had usually been replaced by someone staying over from the previous shift to help for awhile.</p> <p>During an interview with the DoN on 6/15/12 at 1:00 p.m., she indicated it was difficult to replace staff at times. She indicated when a CNA was not replaced, the staff would have to go from one unit to another to help when a resident required care from 2 CNAs</p>						

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	<p>for a task to be completed. She indicated while the CNA was gone, the licensed staff on duty would be required to answer call lights and/or provide care.</p> <p>3.1-17(a)</p>			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which 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</p>	F0441	It is the practice of this provider to establish and maintain an	07/09/2012	

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	<p>ensure a nurse washed her hands each time handwashing was indicated for 1 of 4 nurses (LPN #5) observed for handwashing during medication administration (Resident # 55) and/or a resident treatment (Resident #C).</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #55 was reviewed on at 6/13/12 at 10:00 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, the following: history of MRSA (methicillin resistance staphylococcus aureus), conjunctivitis, and history of peri orbital cellulitis.</p> <p>The clinical record indicated Resident #C had received an antibiotic eye drop to her left eye from 4/17/12 through 5/1/12 for treatment of an eye infection. The resident had a current physician's order, signed 5/19/12, for "Tears Naturale free drops- one drop into the left eye every 3 hours 6 times daily."</p> <p>During an observation on 6/12/12 at 9:40 a.m., the following was observed:</p> <p>LPN #5 used hand gel, applied</p>		<p>infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # C was not identified by the Indiana Department of Health survey team. Resident #55 had no negative outcome related to the alleged deficient practice LPN #5 received re-education related to infection control practices with dressing changes and eye drop administration. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents who receive dressing changes for wounds have the potential to be affected by the alleged deficient practice. Residents who receive eye drops have the potential to be affected by the alleged deficient practice. Licensed nurses were re-educated on completing clean</p>		

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	<p>gloves, and was preparing to administer the eye drop medication to Resident #55. The resident complained of a sore on the back of her head. The resident was wearing a wig. LPN #5 sat the bottle of eye drops on the resident's over the bed table and lifted the resident's wig to examine her head. A loose dressing was noted on the posterior area of the resident's head. LPN #5 picked up the dressing with her gloved hands and tried to look at the wound. The dressing was stuck to the wound. She stopped at this time and replaced the resident's wig. LPN #5 told the resident she would get some normal saline to help loosen the wound and would return later to complete that task.</p> <p>Without washing her hands and with the same gloves on, LPN #5 picked up the bottle of Tears Naturale and walked next to the resident to administer the eye drops. LPN #5 was asked at this time to wash her hands and obtain clean gloves.</p> <p>LPN #5 washed her hands, donned clean gloves, and administered the eye drop medication into the resident's left eye.</p> <p>When she was finished, LPN #5</p>		<p>dressing changes using proper infection control on 6/21/12 and 6/28/12 Licensed nurses were re-educated on eye drop administration using proper infection control on 6/21/12 and 6/28/12. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The Infection Control nurse, and/or designee, monitors for infection control related to nursing practice. Infection control nurse will observe for infection control practices on all shifts, weekly X's 4, monthly X's 2, and quarterly there after. Areas of noncompliance are addressed with the charge nurse and/or certified nursing aide through re-education and/or disciplinary action, as needed. The information is reported to the Director of Nursing Services and IDT Committee no less than quarterly and, as needed. Licensed Nurses are educated on Infection Control Practice upon hire and no less than annually, and as needed. The Director of Nursing Services is responsible for compliance with infection control procedures. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> A dressing change skills validation will be utilized weekly x</p>				

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	<p>removed her gloves and returned to her medication cart, opened it, and put the bottle of eye drops back into the drawer without cleansing the bottle. LPN #5 then used hand gel.</p> <p>2.) The clinical record for Resident #C was reviewed on 6/13/12 at 9:44 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, dementia with behaviors and neurodermatitis.</p> <p>A physician's order, dated 5/31/12, indicated a treatment had been ordered for a skin tear on the resident's left forearm. The order was "cleanse with NS (normal saline), [apply] triple antibiotic ointment cream and cover with suresite [a clear thin dressing] - change every 3 days".</p> <p>During an observation of this treatment on 6/13/12 at 1:05 P.M., the following was observed:</p> <p>LPN #5 obtained the necessary dressing change items and took them to the resident's room and placed them on a clean paper towel. She opened the items and prepared them for use.</p> <p>The resident was up in a reclining geri</p>		<p>4, and monthly, to monitor compliance with the hand washing. A eye drop administration skills validation will be utilized weekly x 4, and monthly, to monitor compliance with the hand washing. The governing IDT committee will review the data. If the threshold for compliance is not met, an action plan will be developed. The IDT/Quality assurance committee will meet no less than quarterly and ad hoc as needed, weekly X's 4, monthly X's 2, and quarterly for 6 months.</p>		

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	<p>chair. His arm was resting on the arm of the chair and the dressing could easily be seen on the top of his forearm. No towel or other item was placed under the resident's arm.</p> <p>LPN #5 donned gloves and removed the old dressing which was slightly stuck. She used some of the normal saline to loosen the dressing. She held a gauze dressing to try and catch some of the normal saline as it was poured over the area. Some of the normal saline ran from the wound area down onto the chair and onto the resident's pants.</p> <p>When the old dressing was loosed, LPN #5 removed it and discarded it and the gloves she was wearing into a trash bag which she had taken to the room and prepared for use. Without washing her hands, she donned new gloves. She then completed the treatment as ordered by the physician. She used a clean tongue depressor to apply the antibiotic ointment.</p> <p>When she was done, she removed her gloves and put them into the trash bag. She picked up the trash bag, the tube of ointment, and the bottle of normal saline and left the room. She did not wash her hands prior to</p>			

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	<p>leaving the room.</p> <p>She disposed of the bagged trash into a covered trash receptacle located in the hall and returned to her treatment cart which was outside of the resident's room. She opened the cart and put the bottle of normal saline and the antibiotic ointment back into the drawer.</p> <p>She then returned to the resident's room and washed her hands. This was the only time she washed her hands during the dressing change.</p> <p>3.) During an interview on 6/14/12 at 4:25 p.m., the DoN indicated LPN #5 had discussed the eye drop administration and the dressing change procedure with her and was aware she had not followed proper infection control procedures.</p> <p>4.) Review of the current facility policy, dated 1/22/12, titled "MEDICATION ADMINISTRATION: OPHTHALMIC (EYE DROP)", provided by the Administrator on 6/14/12 at 3:35 p.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>Instill medication into eyes for local</p>				

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	<p>and/or systemic effects.</p> <p>Procedure:...</p> <p>...2. Perform hand hygiene and apply gloves...."</p> <p>5.) Review of the current facility policy, dated 1/22/12, titled "CLEAN DRESSING APPLICATION", provided by the Administrator on 6/14/12 at 3:35 p.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>Decrease risk of infection in an open area and prevent contaminated drainage from touching clothes ore linen.</p> <p>Procedure:</p> <p>1. Remove the soiled dressing and discard. Avoid crossing over clean supplies with soiled items....</p> <p>...3. Remove and discard gloves. Clean and disinfect bandage scissors if used during soiled part of procedure.</p> <p>4. Perform hand hygiene and apply new gloves....</p>						

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	<p>...6. Apply dressing</p> <p>7. Remove your gloves...</p> <p>...9. Perform hand hygiene. Clean and disinfect bandage scissors, if used...."</p> <p>3.1-18(l)</p>			