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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/11/2013 |
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| NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940 |
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| F000000 | <p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: June 5, 6, 7, 10, and 11, 2013</p> <p>Facility number: 000447 Provider number: 155551 AIM number: 100289950</p> <p>Survey team: Toni Maley, BSW- TC Linn Mackey, RN Karen Koberlein, RN Shelly Reed, RN</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Census payor type: Medicare: 8 Medicaid: 58 Other: 39 Total: 105</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Debora Barth, RN.</p> | F000000 | <p>We at the facility are hereby respectfully requesting this agency to consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficient practices noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p> | |
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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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| F000241 SS=D | <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure catheter bags were covered in a manner to protect 1 resident's dignity in a sample of 13 residents interviewed for dignity concerns. (Resident #140).</p> <p>Findings include:</p> <p>During a 6/5/13, 2:30 p.m., interview, Resident #140 stated "the bag [catheter] is never covered, everyone can see my p - - - ." During an observation at this time the catheter bag was attached to the side of the wheelchair with no privacy cover to maintain resident dignity.</p> <p>During a 6/6/13, 9:00 a.m., observation, Resident #140 was sitting in a wheelchair watching tv, and talking to a significant other who was sitting on the bed. The catheter bag was attached to the wheelchair and again had no cover over the catheter bag.</p> | F000241 | <p>The urinary collection bag for resident #140 was removed and discarded and replaced with the facility preferred <i>Fig Leaf Dignity</i> urinary collection bag at the time of the survey. All other residents residing in the facility that have urinary catheters have the potential to be affected by this practice. Nursing staff were re-inserviced by the Director of Nursing regarding Maintaining dignity for residents with urinary catheters. The DON and/or designee will randomly complete facility Quality Assurance rounds to review Urinary catheter practices and that dignity is maintained. The random facility rounds will be completed daily Monday-Friday for four weeks, then three times a week for four weeks, then once a week for four weeks, then monthly thereafter. The audit will be documented on the Urinary review form (Attachment A). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The Director of Nursing report of monitoring will be forwarded to</p> | 07/11/2013 | | | |

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| | <p>During a 6/7/13, 8:30 a.m., observation, Resident #140 was sitting in a wheelchair waiting for breakfast in his room. The catheter bag was attached to the wheelchair and again had no privacy cover over the catheter bag. (Resident #140) indicated he would like the bag covered.</p> <p>During a 6/7/13, 9:45 a.m., observation, an unidentified resident was sitting in a wheelchair asleep, with the catheter bag attached to the wheelchair but with a privacy cover in place on this catheter bag.</p> <p>Resident #140's record was reviewed on 6/6/13 at 2:00 p.m.</p> <p>Resident #140's current diagnoses included, but were not limited to, neurogenic bladder, quadriplegia and quadriparesis.</p> <p>Resident #140 had a current, 5/3/13, physician order for continuous placement of an 18 French, 30 cc Foley catheter due to a diagnosis of neurogenic bladder. The Foley catheter was also ordered to be changed every 30 days and as needed.</p> <p>3.1-3(t)</p> | | the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly. | | |

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| F000250 SS=E | <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure residents who received "as needed" psychoactive medication had descriptive documentation of the behavioral event and documentation of personalized interventions which occurred prior to the administration of the "as needed" medication for 3 of 3 residents reviewed for the use of "as needed" psychoactive medication in a sample of 10 residents reviewed for unnecessary medication (Resident #23, #42 and #129).</p> <p>Findings include:</p> <p>1. Resident #129's record was reviewed on 6/7/13 at 11:30 am.</p> <p>Resident # 129's current diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety and depression.</p> <p>Resident #129 had current, 2/18/13, physician's orders for Lorazepam 0.5 mg (an anti-anxiety) every 6 hours "as needed" for anxiety related to</p> | F000250 | Resident #23, #42, and #129's individualized behavior care plans were reviewed and revised as indicated. Resident #23, #42, and #129's individualized behavior sheets were reviewed and nurses were re-educated at the time of the survey regarding thorough descriptive documentation of behavioral events which includes such things as location, who was present in the area, the events that preceded the behavior, etc. All residents residing in the facility that exhibit behaviors and receive "as needed" (PRN) medications have the potential to be affected by this deficient practice. The facility Behavior Management and Psychoactive Medications policy and procedure were reviewed and revised as indicated. Nursing staff were re-inserviced by the Social Service Director and Director of Nursing regarding the revised facility policy for Behavior Management and Psychoactive Medications including the need for thorough descriptive documentation of behavioral events which includes such things as location, who was present in the area, the events that preceded the behavior, etc. The | 07/11/2013 | | | |

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| | <p>dementia with delirium.</p> <p>Resident #129's Medication Administration Records for May 2013 and June 1 through 10, 2013, indicated the resident received 12 doses of "as needed" Lorazepam during this 41 day period as follows: 5/13/13, 4:14 p.m., 5/14/13, 2:36 p.m., 5/16/13, 4:01 p.m., 5/17/13, 3:13 p.m., 5/18/13, 3:57 p.m., 5/20/13, 4:02 p.m., 5/24/13, 12:41 p.m., 5/25/13, 3:14 p.m., 5/30/13, 3:35 p.m., 6/3/13, 2:23 p.m., 6/7/13, 7:30 p.m., 6/9/3, 1:53 p.m.</p> <p>Resident #129 had current, 5/16/13, care plan problem regarding wanting to go home, becoming anxious, and confusion related to dementia. Approaches to this problem included, but were not limited to, provide her with a newspaper and other things to look at and any television show such as "Price is Right "for some independent activities and to provide a diversion when she was getting restless. Try diversionary tactics to help take her mind off of leaving by talking to her about her past interest. She loved to play golf. She was an excellent swimmer and a very good bridge player. She worked in accounting for a card company and loved to travel. She had retained a</p> | | <p>nursing staff will be re-inserviced by the Social Service Director and Director of Nursing regarding the revised facility policy for Behavior Management and Psychoactive Medications monthly for three months then quarterly thereafter. The revised policy included but is not limited to: the nurse or social services will complete the Behavior sheet upon being notified of or witnessing a behavior, social services will complete follow-up documentation of behaviors under progress notes, residents that are on Behavior Management Programs will have documentation of behavior symptoms completed every shift by the nursing staff to increase accurate documentation and assessment of the residents behaviors, residents that have new behaviors will have documentation on behavior for two weeks to determine if the behavior is ongoing. Social Services will complete a behavior assessment with the nursing department prior to the end of the two week observation for all new or worsening behaviors; social services will complete a progress note at the end of the two weeks of routine documentation. Behavior sheets will be reviewed daily Monday –Friday by the intradisciplinary team to ensure accuracy (ongoing). Any concerns noted will receive immediate follow-up. PRN medications</p> | | | | |

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| | <p>strong identity of being wife and a mother.</p> <p>Resident #129 had a current, 5/15/13, care plan problem regarding behavioral problems related to cognitive loss, delusional thinking, throwing objects, yelling, crying and cursing. This problem originated, 2/18/13. Approaches to this problem included to monitor behavior episodes and attempt to determine underlying cause: consider location, time of day, persons involved, and situation. Document behaviors and potential cause.</p> <p>For the twelve "as needed" Lorazepam administrations, the clinical record lacked descriptive documentation of the event that proceeded the administration. The documentation did not list location, persons involved or the situation in accordance with the plan of care. The clinical record lacked any documentation to indicate how the treated behavior distressed the resident or negatively impacted her quality of life. The Behavior Sheets which identified interventions attempted prior to the administration of the Lorazepam did not list any resident specific interventions such as newspaper, "Price is Right" or like</p> | | <p>administered will be reviewed weekly by the Director of Nursing and the Social Service Director to ensure appropriate thorough and accurate documentation has been completed prior to administration (ongoing). Any concerns noted will receive immediate follow-up. The facility contract Pharmacist will review PRN medications monthly and submit Pharmacy recommendations to the physicians as indicated requesting discontinuation of PRN medications (ongoing). The facility contract Psychiatrist will review medications monthly and attempt reductions and discontinuation of PRN medications (ongoing). The Director of Nursing and Social Service Director report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p> | | |

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| | <p>program, talked about past interest: swimming, bridge, accounting, golf, being a wife or mother in accordance with the plan of care for 8 of the 12 events as follows: 5/16/13, 5/18/13, 5/20/13, 5/24/13, 5/25/13, 5/30/13, 6/3/13, 6/9/13.</p> <p>During a 6/5/13, 11:35 a.m., lunch observation, Resident #129 sat calmly at her table and ate her lunch.</p> <p>During a 6/7/13, 8:25 a.m., observation, Resident #129 ate her breakfast in a calm manner.</p> <p>During a 6/7/13, 9:55 a.m., observation, Resident #129 participated in an activity in a calm manner.</p> <p>2. Resident #23's record was reviewed on 6/7/13 at 11:30 a.m.</p> <p>Resident #23's current, diagnoses included, but were not limited to, dementia with behavioral disturbances, depression and anxiety.</p> <p>Resident #23 had a current, 4/8/13, physician's order for Xanax 0.25 mg (an anti-anxiety medication) "as needed" 2 times daily for anxiety.</p> <p>Resident #23's Medication</p> | | | | | | |

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| | <p>Administration Record for May, 2013 through June 10, 2013, indicated the resident received 24 doses of "as needed" Xanax during this 41 day period as follows:</p> <p>5/2/13, 10:10 p.m., 5/6/13, 3:14 a.m., 5/6/13, 11:26 p.m., 5/7/13, 9:31 p.m. 5/9/13, 10:35 a.m., 5/10/13, 12:25 p.m., 5/10/13, 8:00 p.m., 5/11/13, 7:00 p.m. 5/12/13, 7:30 p.m., 5/13/13, 7:44 a.m., 5/14/13, 1:46 p.m., 5/15/13, 6:30 p.m. 5/16/13, 7:00 p.m., 5/20/13, 12:24 p.m., 5/20/13, 10:00 p.m., 5/21/13, 6:28 p.m. 5/21/13, 11:00 p.m., 5/24/13, 12:43 p.m., 5/26/13, 12:32 p.m., 5/31/13, 9:01 p.m. 6/3/13, 2:23 p.m., 6/7/13, 8:08 p.m., 6/8/13, 2:34 p.m., 6/9/13, 9:42 p.m.</p> <p>Resident #23 had a current 3/11/13, care plan problem regarding the need for an anti-anxiety medication. Approaches to this problem included monitor/record occurrence of target behavioral symptoms (specify: disrobing, inappropriate response to verbal communication, increased anxiety, violence/aggression towards staff/others.</p> <p>Resident #23 had a current, 4/29/13, care plan problem regarding the use</p> | | | | |

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| | <p>of psychotropic medication related to dementia with behavioral disturbances. An approach to this problem was do not begin care if resident is agitated, talk with resident, allow time to calm and re-approach, explain care, use simple sentences, walk with resident, place in bed for a nap, remove from source of agitation and push in wheel chair as it soothes resident.</p> <p>Other than push in wheelchair, Resident #23 did not have care plan approaches had not been individualized to resident likes, interests or past history.</p> <p>For the 24 administrations of "as needed" Xanax, the clinical record lacked descriptive documentation of the event threat preceding the administration of the medication. The documentation did not list location, persons involved or the situation. The clinical record lacked any documentation to indicate how the treated behavior distressed the resident or negatively impacted her quality of life.</p> <p>During a 6/5/23, 11:35 a.m. to 12:10 p.m., lunch observation, Resident #23 periodically moved about and asked repetitive questions. The resident</p> | | | | | | |

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| | <p>calmed when spoken to directly.</p> <p>During a 6/5/13, 2:25 p.m., observation, Resident #23 slept in her bed.</p> <p>During a 6/6/13, 8:25 a.m., observation, Resident #23 ate breakfast in a calm manner.</p> <p>During a 6/7/13, 11:40 a.m. observation, Resident #23 participated in an activity in a calm manner.</p> <p>3. Resident #42's record was reviewed 6/7/13, 12:30 p.m.</p> <p>Resident #42's current diagnoses included, but were not limited to, anxiety state and dementia with behavioral disturbance.</p> <p>Resident #42 had a current, 6/29/11, physician's order for Lorazepam 0.5 mg (an anti-anxiety medication) "as needed" up to three times daily for anxiety.</p> <p>Resident #42's Medication Administration Record for May, 2013 and June 1 through 10, 2013 indicated she had received 13 doses of "as needed" Lorazepam during this 41 day period as follows:</p> | | | | | | |

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| | <p>5/6/13, 8:26 p.m., 5/7/13, 7:00 p.m., 5/10/13, 6:00 p.m., 5/11/13, 8:00 p.m. 5/12/13, 3:45 p.m., 5/12/13, 8:30 p.m., 5/15/13, 6:00 p.m., 5/16/13, 6:00 p.m. 5/20/13, 3:36 p.m., 5/20/13, 9:00 p.m., 5/25/13, 3:25 p.m., 6/4/13, 2:24 p.m. 6/8/13, 3:53 p.m.</p> <p>Resident #42 had a current, 5/9/13, care plan problem regarding depression and anxiety. Approaches to this problem included, but were not limited to, talk with resident, discuss old memories, involve resident in activities, involve in a task, distract resident with magazines, books and television and offer snack/fluids.</p> <p>Resident #42 had a current, 5/9/23, care plan problem regarding behavioral issues. Approaches to this problem included, but were not limited to, offer silverware to polish, offer strolls in wheelchair and offer towel folding activity.</p> <p>For the 13 doses of "as needed" Lorazepam, the clinical record lacked descriptive documentation of the event threat preceding the administration of the medication. The documentation did not list location, persons involved or the situation.</p> | | | | | | |

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| | <p>The clinical record lacked any documentation to indicate how the treated behavior distressed the resident or negatively impacted her quality of life. The Behavior Sheets which documented interventions prior to administration of the medication lacked documentation of implementation of individualized approaches such as, silverware polishing, strolls, towel folding, discuss old memories, offer books or magazines in accordance to the plan of care for 8 of the 13 events as follows:</p> <p>5/10/13, 6:00 p.m., 5/12/13, 3:45 p.m., 5/16/13, 6:00 p.m., 5/20/13, 3:36 p.m., 5/20/13, 8:30 p.m., 5/25/13, 3:25 p.m., 6/4/13, 2:24 p.m., 6/8/13, 3:53 p.m.</p> <p>During a 6/5/13, 2:27 p.m., observation, Resident #42 sat in her wheelchair in an activity with her eyes closed and her chin to her chest.</p> <p>During a 6/6/13, 8:25 a.m., observation, Resident #42 ate breakfast in a calm manner.</p> <p>During a 6/6/13, 9:56 a.m., observation, Resident #42 sat in her wheelchair with her chin to her chest and her eyes closed during an activity.</p> | | | | | | |

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| | <p>4. A current, undated, facility policy titled "Psychopharmacological Medication Review meeting/Committee," which was provided by the Social Services Director on 6/10/13 at 4:30 p.m., indicated the following:</p> <p>"...Social Services will focus on no-pharmacological interventions needed to decrease psychosocial problems. ...3. The Social Service Director along with members of the Interdisciplinary Team shall develop and implement non-pharmacological mood and behavior interventions in an effort to attempt gradual dose reduction and/or eliminate the need for such medications...."</p> <p>5. During a 6/10/13, 3:24 p.m., interview with the Social Services Director and the Director of Nursing, both Department Heads, indicated without descriptive documentation of a behavioral event which includes such things as location, who was present, the events that proceeded the behavior the resident could not be assessed for causative factors and a plan developed to prevent reoccurrence.</p> <p>3.1-34(a)</p> | | | | |

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| F000315 SS=D | <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to prevent urinary tract infections for 2 of 4 residents reviewed for urinary catheter use in a sample of 4 who met the criteria for catheter use. (Resident #10 and Resident #52)</p> <p>Findings include:</p> <p>1. During catheter care observation on 6/11/13 at 8:45 a.m., CNA #2 provided catheter care to Resident #10. During the catheter care observation, Resident #10's bag was touching the floor.</p> <p>During record review on 6/11/13 at 9:30 a.m., the Minimum Data Set (MDS) assessment indicated Resident #10 as moderately cognitively impaired. Resident #10 received the following Activities of</p> | F000315 | <p>The urinary collection bag for resident #10 has been replaced with a urinary collection bag designed specifically for residents whom require low beds for safety. The resident's individualized plan of care was reviewed and no changes were indicated. Resident #52 has had a urinary drainage collection bag holder added to the wheelchair for placement of the bag and tubing. The urinary collection bag and tubing are appropriately placed in the urinary collection holder underneath the resident's wheelchair. The resident's individualized plan of care was reviewed and revised as indicated. All other residents residing in the facility that have urinary catheters have the potential to be affected by this practice. Nursing staff were re-inserviced by the Director of Nursing regarding placement of urinary catheter to prevent Urinary tract infections. The DON</p> | 07/11/2013 | | | |

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| | <p>Daily Living (ADL) assistance: transfer-extensive assist with two person physical help from staff, ambulation- did not occur, dressing-extensive assist with one person physical assist, hygiene and bathing-extensive assist with one person physical assist, toilet use-extensive assist with bowel and indwelling catheter for bladder.</p> <p>Resident #10 had diagnoses that included, but were not limited to, dementia, Alzheimer's disease, neurogenic bladder, osteoporosis, anxiety and dysphagia.</p> <p>A care plan dated 2/27/13, indicated Resident #10 had a 16 French, indwelling catheter. The care plan included the following interventions: "position catheter bag and tubing below the level of the bladder and away from entrance room door, change catheter every 30 days, document intake and output, monitor for signs and symptoms of discomfort on urination, frequency and pain and report signs and symptoms of a urinary tract infection to the Physician."</p> <p>A urinalysis was collected on 4/11/13 and indicated Resident #10 had 4+ blood, 3+ protein, 1+ urobilinogen, 4+</p> | | <p>and/or designee will randomly complete facility Quality Assurance rounds to review Urinary catheter practices and that appropriate placement of the urinary catheter and tubing is maintained. The random facility rounds will be completed daily Monday-Friday for four weeks, then three times a week for four weeks, then once a week for four weeks, then monthly thereafter. The audit will be documented on the Urinary review form (Attachment A). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p> | | |

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| | <p>leukocytes and 6-20 white blood cells in her urine. On 4/11/13, Resident #10 was given Ciprofloxacin (antibiotic) 500 mg twice daily for 7 days for a urinary tract infection.</p> <p>2. During observation on 6/7/13 at 9:50 a.m., Resident #52 was asleep in his wheelchair in his room. Resident #52 was observed to have a Foley catheter in place and the tubing was touching the floor. Approximately 3" of a reddish-brown residue was noted in the bottom of the tubing.</p> <p>During observation on 6/7/13 at 11:27 a.m., Resident #52 was observed seated in the dining room. Resident #52 was observed to have a Foley catheter in place and the tubing was touching the floor.</p> <p>During observation on 6/11/13 at 8:30 a.m., Resident #52 was observed to be seated in his wheelchair in his room. Resident #52 was observed to have a Foley catheter in place and the tubing was touching the floor.</p> <p>During record review on 6/7/13 at 10:00 a.m., the Minimum Data Set (MDS) assessment, dated 5/23/13, indicated Resident #52 was unable to complete the Brief Interview Mental Status (BIMS) assessment. Resident</p> | | | | | | |

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| | <p>#52 required the following activity of daily living assistance: bed mobility-extensive assistance with one person physical assist, transfer-extensive assistance with two person physical assist, dressing-extensive assistance with one person physical assist, eating-extensive assistance with one person physical assist, toilet use-extensive assistance with two person physical assist and personal hygiene-extensive assistance with one person physical assist.</p> <p>Resident #52's record indicated Resident #52 had diagnoses that included, but were not limited to, atonic bladder, hypertension, gout, dementia with behaviors, Alzheimer's disease, hypertrophy of the prostate, chronic kidney disease and anxiety.</p> <p>A care plan, dated 5/24/13, indicated Resident #52 had a 22 French, indwelling catheter. The care plan included the following interventions: "catheter care every shift, position tubing below the level of the bladder, change Foley catheter and drainage bag every month, check tubing for kinks each shift, may use Foley catheter leg bag or may use Foley drainage bag and monitor and document intake and output as per</p> | | | | | | |

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| | <p>facility policy."</p> <p>A urinalysis was collected on 2/14/13 and indicated Resident #52 had a large amount of leukocytes, 3+ bacteria and was positive for nitrates. The culture and sensitivity indicated Resident #52's urine grew Providencia Sturtii (gram negative bacterium). On 2/14/13, Resident #52 was started on Rocephin (antibiotic) intravenously 1 gram for 7 days.</p> <p>3. During an interview on 6/11/13 at 8:00 a.m., the DoN indicated the facility did not have a specific policy related to catheter tubing touching the floor.</p> <p>During an interview on 6/11/13 at 8:35 a.m., Infection Control Nurse/LPN #1 indicated the best practice was to not allow the catheter or tubing to touch the floor.</p> <p>3.1-41(a)(2)</p> | | | | | | |

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| F000322 SS=D | <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to correctly check for placement of a gastric tube, prior to administrating medication for 1 of 1 residents observed for gastric tube medication administration in a sample of 25 observations of medication administration. (Resident # 10).</p> <p>Findings include:</p> <p>During a medication observation on 6/10/13 at 3:30 p.m. with LPN # 5, she was observed to fill a syringe with water then place the syringe into the gastric tube. She pushed the water into Resident #10's gastric tube. She had a stethoscope over the upper</p> | F000322 | <p>LPN #5 received immediate re-education regarding following facility policy and physicians orders related to auscultation for ensuring placement of a gastric tube. Resident #10 was reassessed using the appropriate auscultation method per facility policy and physicians order. Resident #10's gastric tube was noted to be appropriately placed. The resident was assessed by the RN/Director of Nursing and noted to have no signs or symptoms related to incorrect auscultation for placement by the LPN. All other residents residing in the facility that receive eternal nutrition or medication have the potential to be affected by this deficient practice. Nursing staff was re-inserviced by the Director of Nursing regarding facility policy</p> | 07/11/2013 | |

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| | <p>abdomen. She indicated she was checking the placement of the gastric tube.</p> <p>Resident # 10's record was reviewed on 6/11/13 at 8:00 a.m.</p> <p>Resident # 10's diagnoses included, but were not limited to, dementia, gastrostomy, dysphasia (difficulty swallowing), and protein calorie malnutrition.</p> <p>Resident #10 had a current, 6/5/13, order to check placement of gastric tube with an air bolus before feeding and before giving medications.</p> <p>Resident # 10 had a current, 6/6/13, care plan problem regarding use of a gastric tube. An approach to this problem was to check for tube placement and gastric contents/residual volume per facility policy.</p> <p>Review of a current, facility policy titled "Medication Administered through an Enteral Tube [gastric tube]," which was provided by the nurse consultant at 3:49 p.m. on 6/10/13, indicated the following: "Check placement of the Enteral tube per facility policy."</p> | | <p>and procedure for Medications Administered Through an Enteral Tube, Gastric Tube Feeding via Continuous Pump, and Gastric Tube Feeding via Syringe (Intermittent/Bolus). Return competency demonstrations were completed by the facility nurses with the Director of Nursing to ensure comprehension and knowledge of the accurate method for appropriate auscultation method per facility policy. Random competency observations will completed by the Director of Nursing and/or Designee three times a week for four weeks, then once a week for four weeks, then once a week every other week for four weeks, then monthly thereafter. The audit will be documented on the Gastric Tube Competency Evaluation form (Attachment C). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p> | | | | |

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| | An Interview on 6/10/13, at 4:55 p.m., with the nurse consultant indicated there was not a policy for checking placement of a gastric tube. The standard practice was to check for placement of a gastric tube with an air bolus. 3.1-44(a)(2) | | | |

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| F000325 SS=D | <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to provide the recommended nutritional supplement for an "at risk" resident for 1 of 3 residents reviewed in a sample of 6 who met the criteria for being underweight. (Resident #102)</p> <p>Findings include:</p> <p>During an interview on 6/10/13 at 3:26 p.m., Dietary Manager #4 indicated Resident #102 received a Magic Cup (nutritional supplement) daily at 10:00 a.m.</p> <p>During record review on 6/7/13 at 8:47 a.m., the Minimum Data Set (MDS) assessment, dated 5/6/13, indicated Resident #102 was severely cognitively impaired. Resident #102 required the following activity of daily living assistance: eating-extensive assistance with one person physical</p> | F000325 | Resident #102 is currently receiving a magic cup daily at 10am. Nursing staff received a physician order for the resident to receive a magic cup daily at 10am. The resident's individualized plan of care was reviewed and no changes were indicated. All residents who receive dietary recommendations for nutritional supplements have the potential to be affected by this deficient practice. Dietary staff was re-inserviced by the Dietary Manager regarding providing supplements to residents per their individualized plan of care. The Dietary Manager was re-inserviced by the Dietician regarding completing care plan revision after the order for the nourishment has been received. The Dietary manager will revise residents' individualized plan of care to include new or revised orders for nourishments after confirmation the order has been received (ongoing). All new dietary nourishments orders will | 07/11/2013 | | | |

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| | <p>assist.</p> <p>Resident #102 had diagnoses that included, but were not limited to, anemia, dysphagia, peripheral vascular disease, hypertension, chronic kidney disease, anxiety, osteoarthritis,. psychosis and dementia with behaviors.</p> <p>Resident #102 current height was 62 inches, weight 97 lbs and Body Mass Index (BMI) 17.7. Resident #102's previous weights included: 6/5/13 95.0# (pounds), 5/3/13 97.0#, 4/3/13 98.8#, 3/4/13 103.8#, 2/8/13 99.8#, 1/4/13 96.0#, 12/27/12 92#, 12/20/12 90.6# and 12/13/12 89.0#.</p> <p>A care plan, dated 3/6/13, included involuntary weight loss and chewing difficulty. The interventions included, but were not limited to, "offer Magic Cup (nutritional supplement) at 10:00 a.m., provide resident with as much assistance as she will allow, monitor food intake, serve ice cream at lunch, pudding cup at dinner and high calorie and protein cereal at breakfast."</p> <p>During observation on 6/11/13 at 10:10 a.m., Resident #102 was not provided the recommended nutritional supplement as ordered.</p> | | <p>reviewed daily Monday-Friday during the morning Intradisciplinary meeting. All new dietary nourishments orders will be followed up on accordingly. The Dietary manager will randomly audit nutritional supplements to ensure accuracy of the delivery of supplements to the residents four times a week for four weeks, once a week for four weeks, once a week every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. The Dietary Manager will document the random audit on the nutritional supplement compliance form (Attachment B). Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The Dietary Manager report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p> | | |

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| | <p>During an interview on 6/11/13 at 1:10 p.m., Dietary Manager #4 indicated the dietary recommendations from 12/17/12 did not get put on a dietary card or Treatment Administration Record (TAR) for the Magic Cup supplement.</p> <p>3.1-46(a)(1)</p> | | | |

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| F000329 SS=E | <p>483.25(I) 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 observation, interview and record review, the facility failed to ensure resident who were administered "as needed" anti-anxiety medications had complete descriptive documentation of the resident's behavioral symptom and event that lead to the use of the "as needed" medication for 3 of 3 residents who had orders for "as needed" anti-anxiety medication in a sample of 10 residents reviewed for unnecessary medications (Residents</p> | F000329 | Resident #23, #42, and #129's individualized behavior care plans were reviewed and revised as indicated. Resident #23, #42, and #129's individualized behavior sheets were reviewed and nurses were re-educated at the time of the survey regarding thorough descriptive documentation of behavioral events which includes such things as location, who was present in the area, the events that proceeded the behavior, etc. All residents residing in the facility that exhibit behaviors and receive "as | 07/11/2013 | |

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| | <p>#42, #23 and #129).</p> <p>Findings Include:</p> <p>1. Resident #129's record was reviewed on 6/7/13 at 11:30 am.</p> <p>Resident # 129's current diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety and depression.</p> <p>Resident #129 had current, 2/18/13, physician's orders for Lorazepam 0.5 mg (an anti-anxiety) every 6 hours "as needed" for anxiety related to dementia with delirium.</p> <p>Resident #129's Medication Administration Records for May 2013 and June 1 through 10, 2013, indicated the resident received 12 doses of "as needed" Lorazepam during this 41 day period as follows: 5/13/13, 4:14 p.m., 5/14/13, 2:36 p.m., 5/16/13, 4:01 p.m., 5/17/13, 3:13 p.m., 5/18/13, 3:57 p.m., 5/20/13, 4:02 p.m., 5/24/13, 12:41 p.m., 5/25/13, 3:14 p.m., 5/30/13, 3:35 p.m., 6/3/13, 2:23 p.m., 6/7/13, 7:30 p.m., 6/9/3, 1:53 p.m.</p> <p>Resident #129 had current, 5/16/13, care plan problem regarding wanting</p> | | <p>needed" (PRN) medications have the potential to be affected by this deficient practice. The facility Behavior Management and Psychoactive Medications policy and procedure were reviewed and revised as indicated. Nursing staff were re-inserviced by the Social Service Director and Director of Nursing regarding the revised facility policy for Behavior Management and Psychoactive Medications including the need for thorough descriptive documentation of behavioral events which includes such things as location, who was present in the area, the events that preceded the behavior, etc. The nursing staff will be re-inserviced by the Social Service Director and Director of Nursing regarding the revised facility policy for Behavior Management and Psychoactive Medications monthly for three months then quarterly thereafter. The revised policy included but is not limited to: the nurse or social services will complete the Behavior sheet upon being notified of or witnessing a behavior, social services will complete follow-up documentation of behaviors under progress notes, residents that are on Behavior Management Programs will have documentation of behavior symptoms completed every shift by the nursing staff to increase accurate documentation and assessment of the residents</p> | | | | |

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| | <p>to go home, becoming anxious, and confusion related to dementia. Approaches to this problem included, but were not limited to, provide her with a newspaper and other things to look at and any television show such as "Price is Right "for some independent activities and to provide a diversion when she was getting restless. Try diversionary tactics to help take her mind off of leaving by talking to her about her past interest. She loved to play golf. She was an excellent swimmer and a very good bridge player. She worked in accounting for a card company and loved to travel. She had retained a strong identity of being wife and a mother.</p> <p>Resident #129 had a current, 5/15/13, care plan problem regarding behavioral problems related to cognitive loss, delusional thinking, throwing objects, yelling, crying and cursing. This problem originated, 2/18/13. Approaches to this problem included: to monitor behavior episodes and attempt to determine underlying cause: consider location, time of day, persons involved, and situation. Document behaviors and potential cause.</p> <p>For the twelve "as needed"</p> | | <p>behaviors, residents that have new behaviors will have documentation on behavior for two weeks to determine if the behavior is ongoing. Social Services will complete a behavior assessment with the nursing department prior to the end of the two week observation for all new or worsening behaviors; social services will complete a progress note at the end of the two weeks of routine documentation. Behavior sheets will be reviewed daily Monday –Friday by the intradisciplinary team to ensure accuracy (ongoing). Any concerns noted will receive immediate follow-up. PRN medications administered will be reviewed weekly by the Director of Nursing and the Social Service Director to ensure appropriate thorough and accurate documentation has been completed prior to administration (ongoing). Any concerns noted will receive immediate follow-up. The facility contract Pharmacist will review PRN medications monthly and submit Pharmacy recommendations to the physicians as indicated requesting discontinuation of PRN medications (ongoing). The facility contract Psychiatrist will review medications monthly and attempt reductions and discontinuation of PRN medications (ongoing). The Director of Nursing and Social Service Director report of monitoring will be forwarded to the</p> | | |

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| | <p>Lorazepam administrations, the clinical record lacked descriptive documentation of the event that preceded the administration. The documentation did not list location, persons involved or the situation in accordance with the plan of care. The clinical record lacked any documentation to indicate how the treated behavior distressed the resident or negatively impacted her quality of life. The Behavior Sheets which identified interventions attempted prior to the administration of the Lorazepam did not list any resident specific interventions such as newspaper, "Price is Right" or like program, talked about past interest: swimming, bridge, accounting, golf, being a wife or mother in accordance with the plan of care for 8 of the 12 events as follows: 5/16/13, 5/18/13, 5/20/13, 5/24/13, 5/25/13, 5/30/13, 6/3/13, 6/9/13.</p> <p>During a 6/5/13, 11:35 a.m., lunch observation, Resident #129 sat calmly at her table and ate her lunch.</p> <p>During a 6/7/13, 8:25 a.m., observation, Resident #129 ate her breakfast in a calm manner.</p> <p>During a 6/7/13, 9:55 a.m., observation, Resident #129</p> | | Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly. | | | | |

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| | <p>participated in an activity in a calm manner.</p> <p>2. Resident #23's record was reviewed on 6/7/13 at 11:30 a.m.</p> <p>Resident #23's current, diagnoses included, but were not limited to, dementia with behavioral disturbances, depression and anxiety.</p> <p>Resident #23 had a current, 4/8/13, physician's order for Xanax 0.25 mg (an anti-anxiety medication) "as needed" 2 times daily for anxiety.</p> <p>Resident #23's Medication Administration Record for May, 2013 through June 10, 2013, indicated the resident received 24 doses of "as needed" Xanax during this 41 day period as follows: 5/2/13, 10:10 p.m., 5/6/13, 3:14 a.m., 5/6/13, 11:26 p.m., 5/7/13, 9:31 p.m., 5/9/13, 10:35 a.m., 5/10/13, 12:25 p.m., 5/10/13, 8:00 p.m., 5/11/13, 7:00 p.m. 5/12/13, 7:30 p.m., 5/13/13, 7:44 a.m., 5/14/13, 1:46 p.m., 5/15/13, 6:30 p.m. 5/16/13, 7:00 p.m., 5/20/13, 12:24 p.m., 5/20/13, 10:00 p.m., 5/21/13, 6:28 p.m. 5/21/13, 11:00 p.m., 5/24/13, 12:43 p.m., 5/26/13, 12:32 p.m., 5/31/13,</p> | | | | |

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| | <p>9:01 p.m. 6/3/13, 2:23 p.m., 6/7/13, 8:08 p.m., 6/8/13, 2:34 p.m., 6/9/13, 9:42 p.m.</p> <p>Resident #23 had a current, 3/11/13, care plan problem regarding the need for an anti-anxiety medication. Approaches to this problem included monitor/record occurrence of target behavioral symptoms (specify: disrobing, inappropriate response to verbal communication, increased anxiety, violence/aggression towards staff/others.</p> <p>Resident #23 had a current, 4/29/13, care plan problem regarding the use of psychotropic medication related to dementia with behavioral disturbances. An approach to this problem was do not begin care if resident is agitated, talk with resident, allow time to calm and re-approach, explain care, use simple sentences, walk with resident, place in bed for a nap, remove from source of agitation and push in wheel chair as it soothes resident.</p> <p>Other than push in wheelchair, Resident #23 did not have care plan approaches which had been individualized to resident likes, interests or past history.</p> | | | | | | |

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| | <p>For the 24 administrations of "as needed" Xanax, the clinical record lacked descriptive documentation of the event threat preceding the administration of the medication. The documentation did not list location, persons involved or the situation. The clinical record lacked any documentation to indicate how the treated behavior distressed the resident or negatively impacted her quality of life.</p> <p>During a 6/5/23, 11:35 a.m. to 12:10 p.m., lunch observation, Resident #23 periodically moved about and asked repetitive questions. The resident calmed when spoken to directly.</p> <p>During a 6/5/13, 2:25 p.m., observation, Resident #23 slept in her bed.</p> <p>During a 6/6/13, 8:25 a.m., observation, Resident #23 ate breakfast in a calm manner.</p> <p>During a 6/7/13, 11:40 a.m. observation, Resident #23 participated in an activity in a calm manner.</p> <p>3. Resident #42's record was reviewed 6/7/13, 12:30 p.m.</p> | | | | | | |

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| | <p>Resident #42's current diagnoses included, but were not limited to, anxiety state and dementia with behavioral disturbance.</p> <p>Resident #42 had a current, 6/29/11, physician's order for Lorazepam 0.5 mg (an anti-anxiety medication) "as needed" up to three times daily for anxiety.</p> <p>Resident #42's Medication Administration Record for May, 2013 and June 1 through 10, 2013 indicated she had received 13 doses of "as needed" Lorazepam during this 41 day period as follows: 5/6/13, 8:26 p.m., 5/7/13, 7:00 p.m., 5/10/13, 6:00 p.m., 5/11/13, 8:00 p.m. 5/12/13, 3:45 p.m., 5/12/13, 8:30 p.m., 5/15/13, 6:00 p.m., 5/16/13, 6:00 p.m. 5/20/13, 3:36 p.m., 5/20/13, 9:00 p.m., 5/25/13, 3:25 p.m., 6/4/13, 2:24 p.m. 6/8/13, 3:53 p.m.</p> <p>Resident #42 had a current, 5/9/13, care plan problem regarding depression and anxiety. Approaches to this problem included, but were not limited to, talk with resident, discuss old memories, involve resident in activities, involve in a task, distract resident with magazines, books and</p> | | | | | | |

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| | <p>television and offer snack/fluids.</p> <p>Resident #42 had a current, 5/9/23, care plan problem regarding behavioral issues. Approaches to this problem included, but were not limited to, offer silverware to polish, offer strolls in wheelchair and offer towel folding activity.</p> <p>For the 13 doses of "as needed" Lorazepam, the clinical record lacked descriptive documentation of the event threat preceding the administration of the medication. The documentation did not list location, persons involved or the situation. The clinical record lacked any documentation to indicate how the treated behavior distressed the resident or negatively impacted her quality of life. The Behavior Sheets which documented interventions prior to administration of the medication lacked documentation of implementation of individualized approaches such as, silverware polishing, strolls, towel folding, discuss old memories, offer books or magazines in accordance to the plan of care for 8 of the 13 events as follows: 5/10/13, 6:00 p.m., 5/12/13, 3:45 p.m., 5/16/13, 6:00 p.m., 5/20/13, 3:36 p.m.,</p> | | | |
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| | <p>5/20/13, 8:30 p.m., 5/25/13, 3:25 p.m., 6/4/13, 2:24 p.m., 6/8/13, 3:53 p.m.</p> <p>During a 6/5/13, 2:27 p.m., observation, Resident #42 sat in her wheelchair in an activity with her eyes closed and her chin to her chest.</p> <p>During a 6/6/13, 8:25 a.m., observation, Resident #42 ate breakfast in a calm manner.</p> <p>During a 6/6/13, 9:56 a.m., observation, Resident #42 sat in her wheelchair with her chin to her chest and her eyes closed during an activity.</p> <p>4. A current, undated, facility policy titled "Psychopharmacological Medication Review meeting/Committee," which was provided by the Social Services Director on 6/10/13 at 4:30 p.m., indicated the following:</p> <p>"...Social Services will focus on no-pharmacological interventions needed to decrease psychosocial problems. ...3. The Social Service Director along with members of the Interdisciplinary Team shall develop and implement non-pharmacological mood and behavior interventions in</p> | | | |

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| | <p>an effort to attempt gradual dose reduction and/or eliminate the need for such medications...."</p> <p>5. During a 6/10/13, 3:24 p.m., interview with the Social Services Director and the Director of Nursing, both Department Heads, indicated without descriptive documentation of a behavioral event which includes such things as location, who was present, the events that proceeded the behavior the resident could not be assessed for causative factors and a plan developed to prevent reoccurrence.</p> <p>3.1-48(a)(3)</p> | | | |

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| F000441 SS=D | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (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> | F000441 | The urinary collection bag for resident #10 has been replaced | 07/11/2013 | | | |

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| | <p>provide standards of practice related to urinary catheter bag and tubing touching the floor for 2 of 4 residents reviewed for urinary catheter use in a sample of 4 who met the criteria (Resident #10 and Resident #52) and gastrostomy tube flushing for 1 of 1 residents reviewed for gastrostomy medication administration (Resident #10).</p> <p>Findings include:</p> <p>1. During catheter care observation on 6/11/13 at 8:45 a.m., CNA #2 provided catheter care to Resident #10. During the catheter care observation, Resident #10's bag was touching the floor.</p> <p>During record review on 6/11/13 at 9:30 a.m., the Minimum Data Set (MDS) assessment indicated Resident #10 was moderately cognitively impaired. Resident #10 received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with two person physical help from staff, ambulation- did not occur, dressing-extensive assist with one person physical assist, hygiene and bathing-extensive assist with one person physical assist, toilet use-extensive assist with bowel and</p> | | <p>with a urinary collection bag designed specifically for residents whom require low beds for safety. The resident's individualized plan of care was reviewed and no changes were indicated. Resident #52 has had a urinary drainage collection bag holder added to the wheelchair for placement of the bag and tubing. The urinary collection bag and tubing are appropriately placed in the urinary collection holder underneath the resident's wheelchair. The resident's individualized plan of care was reviewed and revised as indicated. All other residents residing in the facility that have urinary catheters have the potential to be affected by this practice. Nursing staff were re-inserviced by the Director of Nursing regarding placement of urinary catheter to prevent Urinary tract infections. The DON and/or designee will randomly complete facility Quality Assurance rounds to review Urinary catheter practices and that appropriate placement of the urinary catheter and tubing is maintained. The random facility rounds will be completed daily Monday-Friday for four weeks, then three times a week for four weeks, then once a week for four weeks, then monthly thereafter. The audit will be documented on the Urinary review form (Attachment A). Any concerns noted will receive immediate</p> | | |

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| | <p>indwelling catheter for bladder.</p> <p>Resident #10 had diagnoses that included, but were not limited to, dementia, Alzheimer's disease, neurogenic bladder, osteoporosis, anxiety and dysphagia.</p> <p>A care plan, dated 2/27/13, indicated Resident #10 had a 16 French, indwelling catheter. The care plan included the following interventions: "position catheter bag and tubing below the level of the bladder and away from entrance room door, change catheter every 30 days, document intake and output, monitor for signs and symptoms of discomfort on urination, frequency and pain and report signs and symptoms of a urinary tract infection to the Physician."</p> <p>A urinalysis was collected on 4/11/13 and indicated Resident #10 had 4+ blood, 3+ protein, 1+ urobilinogen, 4+ leukocytes and 6-20 white blood cells in her urine. On 4/11/13, Resident #10 was given Ciprofloxacin (antibiotic) 500 mg twice daily for 7 days for a urinary tract infection.</p> <p>2. During an observation on 6/7/13 at 9:50 a.m., Resident #52 was asleep in his wheelchair in his room.</p> | | <p>follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly. LPN #5 received immediate re-education regarding following facility policy and physicians orders related to auscultation for ensuring placement of a gastric tube and following the appropriate infection control practices. Resident #10's enteral piston syringe was replaced. All other residents residing in the facility that receive enteral nutrition or medication have the potential to be affected by this deficient practice. Nursing staff was re-inserviced by the Director of Nursing regarding facility policy and procedure for Medications Administered Through an Enteral Tube, Gastric Tube Feeding via Continuous Pump, and Gastric Tube Feeding via Syringe (Intermittent/Bolus). Return competency demonstrations were completed by the facility nurses with the Director of Nursing to ensure comprehension and knowledge of the accurate method for accessing a gastric tube and adhering to infection control practices per facility policy. Random competency observations will completed by</p> | | |

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| | <p>Resident #52 was observed to have a Foley catheter in place and the tubing was touching the floor. Approximately 3" of a reddish-brown residue was noted in the bottom of the tubing.</p> <p>During observation on 6/7/13 at 11:27 a.m., Resident #52 was observed seated in the dining room. Resident #52 was observed to have a Foley catheter in place and the tubing was touching the floor.</p> <p>During observation on 6/11/13 at 8:30 a.m., Resident #52 was observed to be seated in his wheelchair in his room. Resident #52 was observed to have a Foley catheter in place and the tubing was touching the floor.</p> <p>During record review on 6/7/13 at 10:00 a.m., the Minimum Data Set (MDS) assessment, dated 5/23/13, indicated Resident #52 was unable to complete the Brief Interview Mental Status (BIMS) assessment. Resident #52 required the following activity of daily living assistance: bed mobility-extensive assistance with one person physical assist, transfer-extensive assistance with two person physical assist, dressing-extensive assistance with one person physical assist, eating-extensive assistance with one</p> | | <p>the Director of Nursing and/or Designee three times a week for four weeks, then once a week for four weeks, then once a week every other week for four weeks, then monthly thereafter. The audit will be documented on the Gastric Tube Competency Evaluation form (Attachment C). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p> | | |

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| | <p>person physical assist, toilet use-extensive assistance with two person physical assist and personal hygiene-extensive assistance with one person physical assist.</p> <p>Resident #52 had diagnoses that included, but were not limited to: atonic bladder, hypertension, gout, dementia with behaviors, Alzheimer's disease, hypertrophy of the prostate, chronic kidney disease and anxiety.</p> <p>A care plan, dated 5/24/13, indicated Resident #52 had a 22 French, indwelling catheter. The care plan included the following interventions: "catheter care every shift, position tubing below the level of the bladder, change Foley catheter and drainage bag every month, check tubing for kinks each shift, may use Foley catheter leg bag or may use Foley drainage bag and monitor and document intake and output as per facility policy."</p> <p>A urinalysis was collected on 2/14/13 and indicated Resident #52 had a large amount of leukocytes, 3+ bacteria and positive for nitrates. The culture and sensitivity indicated Resident #52's urine grew Providencia Stuaritii (gram negative bacterium). On 2/14/13, Resident</p> | | | | |

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| | <p>#52 was started on Rocephin (antibiotic) intravenously 1 gram for 7 days.</p> <p>During an interview on 6/11/13 at 8:00 a.m., the DoN indicated the facility did not have a specific policy related to catheter tubing touching the floor.</p> <p>During an interview on 6/11/13 at 8:35 a.m., Infection Control Nurse/LPN #1 indicated the best practice was to not allow the catheter or tubing to touch the floor.</p> <p>During a medication observation on 6/10/13, at 3:30 p.m. with LPN #5, she touched the mat that was on the floor with her hand. She then proceeded to put gloves on without washing her hands. During the procedure of flushing with water prior to medication administration, giving the medication, and doing another flush with water, she laid the syringe (syringe was for multiple use in a 24 hour period.) on the bed sheet next to Resident #10.</p> <p>Resident #10's record was reviewed on 6/11/13 at 8:00 a.m.</p> <p>Resident #10's diagnoses included, but were not limited to, dementia, gastrostomy, dysphasia (difficulty</p> | | | | | | |

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| | <p>swallowing), and protein calorie malnutrition.</p> <p>During a 6/10/13, 4:00 p.m., interview with LPN #1, she indicated that gastric tube syringes should be placed on a clean surface.</p> <p>3.1-18(j)</p> | | | |