STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE MANOR NURSING HOME	1109 E NATIONAL HWY WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Recertification and State Licensure survey. Survey dates: April 23, 24, 28, 29, and 30, 2013 Facility number: 000303 Provider number: 155708 AIM number: 100287530 Survey team: Amy Wininger, RN-TC Terri Walters, RN Dorothy Watts, RN (April 23, 24, and 29, 2014) Sylvia Martin, RN Census bed type: SNF: 3 SNF/NF:40 Total:43 Census payor type: Medicare: 8 Medicaid:29 Other: 6 Total:43 These deficiencies reflect state findings cited in accordance with 410 AIC 16.2. Quality review completed on May 5, 2014, by Janelyn Kulik, RN.	F000000	Please accept the following as our credible allegation of compliance	
F000309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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.			
	A. Based on interview and record review, the facility failed to ensure services were provided, in that, a resident who experienced pain upon admission to the facility did not receive pain medication timely for 1 of 1 residents who met the criteria for review of pain management. This deficient practice resulted in a resident experiencing severe pain without intervention for 6.5 hours. (Resident #6) The facility also failed to ensure care was provided for 1 of 1 resident receiving dialysis services related to not monitoring for bruit/thrill and vital signs on non-dialysis days and for not monitoring for complications after receiving dialysis. (Resident #33) Findings Include: 1. The record for Resident #6 was reviewed on 4/28/14 at 11:57 A.M. The record indicated Resident #6 was admitted to the facility on 11/22/13 at 5:00 P.M., with diagnoses including, but not limited to, congestive heart failure, cellulitis, cardiovascular disease, and a history of chronic pain. The undated initial care plan included, but was not limited to, activities of daily living decline, and pain. The admission physicians orders included, but were not limited to, Lortab (a narcotic	F000309	F – 309 The corrective action taken for those residents found to be affected by the deficient practice is that Resident #6's has been discharged from the facility. Resident #33's care plan and TAR was updated to include documentation related to checking the bruit/thrill, monitoring for complications On April 28, 2014. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* All residents experiencing pain have the potential to be affected. New Pain assessments were completed on all residents and care plans were updated. Facility policy was updated regarding pain management, administrating medication from the EDK and the policy and procedure for Dialysis. All nurses and QMA was in serviced on May 14, 2014on pain management and use of EDK. to ensure deficient practice doesn't occur in the future. There are no other dialysis patients in the facility. The measures or systematic changes	05/16/2014

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	pain medication) 10/500 milligrams(mg) one twice daily as needed for pain, Xanax (an anti-anxiety medication) 0.5 mg at bedtime, and Tylenol (an analgesic medication) 650 mg every four hours for pain as needed. An un-timed Admission Pain Assessment dated 11/22/13 indicated Resident #6 was experiencing leg pain upon admission. The assessment further indicated Resident #6 rated the pain a "9" on a pain scale 0 -10 (0 being no pain and 10 being the worst pain) with the resident's acceptable level of pain to be at "3" . The assessment also indicated Resident #6 had been experiencing non verbal signs of pain including, grimacing, moaning, irritability and fidgeting. A nursing notes dated 11/22/13 at 5:00 P.M., indicated Resident #6 was tearful and demanding upon admission. A nursing note dated 11/22/13 at 8:00 P.M., indicated, " Res (resident) c/o (complaint of) wanting meds (medications) " NOW " (sic) Assured (sic) res that she would get her meds when they arrived from pharmacy ... " A nursing note dated 11/22/13 at 11:30 P.M., indicated medications had arrived except for ordered Lortab and Xanax. The medications were retrieved and administered, at that time, from the facility emergency drug kit (EDK). The record indicated Resident #6 experienced pain upon admission to the facility at 5:00 P.M.and lacked any documentation pharmacological and/or non-pharmacological interventions were offered until 11:30 P.M. (6.5 hours) During an interview with the DON (Director of		that have been put into place to ensure that the deficient practice does not recur is that One on one in - services was conducted for all Nurses and QMA's on pain management , EDK and monitoring dialysis patients checking the bruit/thrill and monitoring for complications. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A pain management audit / Dialyisis audit has been developed to ensure that proper technique is being following while assessing these residents. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. . Completion date: May 16 , 2014	

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	Nursing) and ADON (Assistant Director of Nursing) on 04/28/14 at 1:45 P.M., the DON indicated a newly admitted resident should be provided pain relief as soon as possible and the facility maintained an EDK (Emergency Drug Kit) for that reason. During an interview, at that time, the ADON agreed with the DON and indicated no documentation could be provided that pharmacological and/or non-pharmacological interventions had been attempted to relieve the pain of Resident #6. A policy titled " PAIN MANAGEMENT " was provided on 4/28/14 dated 3:48 P.M., it included, " ...1. The resident will be assessed for pain: a. On (sic) admission, quarterly and with any significant change in status .... 11. Licensed nursing personnel will receive pain management education on hire and no less that annually, This education will include but not be limited to: .... a. different types of pain and treatment modalities, b. Potential impact of pain on physical, mental and psychosocial (sic) well-being .... d. Storage and access of controlled substance ... " 2. Resident #33 was observed on 04/24/14 at 3:00 P.M. resting with eyes closed in a recliner. The record of Resident #33 was reviewed on 04/28/14 at 2:56 P.M. The record indicated the diagnoses of Resident #33 included, but were not limited to, chronic kidney disease-stage 4. The most recent Quarterly MDS (Minimum Data Set Assessment) dated 02/26/14 indicated Resident #33 received dialysis treatments.			

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	A care plan dated 02/26/14 for Hemodialysis included, but was not limited to, interventions of, "...check for bruit and thrill every shift...monitor for pain, numbness, tingling, change in color or temperature of extremity...check vital signs every shift...". The care plan lacked any interventions related to monitoring Resident #33 for complications after receiving dialysis. The April 2014 Physician's Order Recap included, but was not limited to, an order for, "...dialysis treatment three times a week...". The recap lacked any orders related to checking the bruit/thrill, monitoring for complications after receiving dialysis, and/or checking vital signs every shift. The April 2014 Dialysis Communication Records from 04/01/14 through 04/26/14 were reviewed and lacked any documentation related to monitoring the resident for complications after receiving dialysis. The nursing notes from 04/01/14 through 04/26/14 were reviewed and lacked any documentation related to the bruit/thrill being checked on non-dialysis days, monitoring of the resident for complications after receiving dialysis, and/ or the vital signs being checked every shift. The April 2014 TAR (Treatment Administration Record) and MAR (Medication Administration Record) lacked any documentation related to checking the bruit/thrill, monitoring for complications, and/or checking the vital signs from April 1 through April 26., 2014.			

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	During an interview on 04/28/14 at 3:12 P.M., the ADON (Assistant Director of Nursing) indicated no documentation could be provided to indicate the bruit/thrill had been checked on non-dialysis days, Resident #33 had been monitored for complications after receiving dialysis and/or the vital signs had been checked every shift on non-dialysis days during April 2014. The ADON further indicated, at that time, the vital signs and bruit/thrill should have been checked every shift and Resident #33 should have been monitored for complications after dialysis treatments. During an interview on 04/29/14 at 10:30 A.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate the bruit/thrill had been checked on non-dialysis days, the resident had been monitored for complications after receiving dialysis, and/or the vital signs had been checked every shift during the month of April 2014. The DON further indicated, at that time, the care plan interventions had been added to the TAR/MAR. The Policy and Procedure for Dialysis Communication provided by the HFA (Health Facilities Administrator) on 04/29/14 at 2:46 P.M. indicated, "...6. Upon return from the Treatment the Unit should document Shunt (sic) site s/s (signs/symptoms) infection, complication or any other problems that may have arise (sic) during the treatment. Any abnormalities should be followed up on and documented in the patients (sic) Nurses Notes..."			
F000314 SS=G	3.1-37(a) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL			

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	PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F000314	F – 314 The corrective action taken for those residents found to be affected by the deficient practice is that Resident #6' and # 8 have been discharged from the facility. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* All residents at risk for developing pressure ulcers have the potential to be affected. New Braden Scales were completed on all residents identifying those at risk. Interventions were put into place to ensure residents do not develop pressure sores and receive the necessary treatment and services to promote healing. Individual care plans and C.N.A. Assignment sheets were updated accordingly. Facility Initial Care plan was updated to included preventive measures to eliminating pressure ulcers from	05/16/2014
	Based on interview and record review, the facility failed to ensure care was provided, in that, 2 residents admitted without pressure ulcers, developed pressure ulcers for 2 of 3 residents who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident #6 experiencing a deep tissue injury and Resident #8 experiencing a Stage 2 pressure area Findings Include: 1. The record of Resident #6 was reviewed on 4/28/14 at 11:57 A.M., The record indicated Resident #6 was admitted to the facility on 11/22/13 at 5:00 P.M. with diagnoses including, but not limited to, congestive heart failure, cellulitis, cardiovascular disease and a history of chronic pain. The record further indicated Resident #6 was discharged on 12/01/13. The Minimum Data Set Assessment (MDS) dated 11/29/13, indicated Resident #6 required extensive assist of two people to for transfers and toileting, extensive assist of one with bed mobility, unable to transfer self, and had limited range of motion in both upper and lower extremities.			

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	The undated initial care plan lacked any documentation related to pressure. The Admission Nursing Assessment dated 11/22/13 at 5:00 P.M., indicated Resident #6 required the assistance of 2 staff for transfers and used a wheelchair. The assessment further indicated Resident #6 was admitted with no areas of pressure. A Braden Pressure Ulcer Risk scale dated 11/22/13, indicated Resident #6 was at risk for the development of pressure. A Nurses note dated 12/01/13 at 1:00 P.M., indicated, "...noted post (posterior) R(right) thigh an abraided (sic) area from edge of w/c (wheel chair) seat et legs swollen 2.2 x 0.5 red c(with) purple edges. 0 (no) drng(drainage)..." A Weekly Pressure Ulcer Progress Report dated 12/01/13, indicated Resident #6 experienced an, "...abrasion right thigh post (posterior) r/t (related to) w/c (wheel chair seat..." on 12/01/14. The report further indicated, "...2.2 cm (centimeter) length X 0.5 cm width (no depth recorded)...red purple edges..." and included a new intervention of "pad w/c edge-up in recliner". A Pressure Ulcer Staging form provided by the ADON (Assistant Director of Nursing) on 04/28/14 at 3:48 P.M. indicated, "...Bruising indicates suspected deep tissue injury...Suspected Deep Tissue Injury:...Purple or maroon localized area of discolored intact skin...due to damage of underlying soft tissue from pressure and/or shear..."		occurring. Upon Admission a Braden scale will be completed. If identified as at risk for pressure ulcer interventions will be put in place, care plan and assignment sheet will be updated. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that Facility policy was updated regarding Preventive of pressure ulcers. All nursing staff was in serviced on May 8, 2014 and on May 14,2014 *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Preventive Pressure audit has been developed to ensure that proper procedure is being following ensuring residents donot develop pressure ulcers. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.	

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	2. The clinical record for Resident #8 was reviewed on 04/28/14 at 2:00 P.M. The record indicated Resident #8 was admitted to the facility on 01/28/14 at 3:45 P.M. and discharged on 02/19/14. The record indicated the diagnoses of Resident #8 included, but were not limited to, dementia, major depressive disorder and hypertension. The MDS (Minimum Data Set Assessment) dated 02/4/14 indicated Resident #8 required extensive assist of one person with transfers and bed mobility. The Initial Care Plan dated 01/28/14 lacked any documentation related to pressure. The Admission Nursing Assessment dated 01/28/14 at 3:45 P.M., indicated Resident #8 required the assistance of 1 staff for transfers. The assessment further indicated, Resident #8 was admitted with no areas of pressure. A Braden Risk Assessment score dated 01/28/14 indicated Resident #8 was at risk for the development of pressure. A Weekly Pressure Ulcer Progress Report dated 02/11/14 indicated Resident #8 experienced a, "Stage 2 pressure ulcer 0.4 cm length X 0.3 cm width X 0.2 cm depth..." The report further indicated, "...Risk factors/cause...immobility..." and included, but was not limited to, an intervention of, "...turned q (every) 2 hours..." A Pressure Ulcer Staging form provided by the ADON on 04/28/14 at 3:48 P.M. indicated, "...Stage II: ...Partial thickness loss of dermis presenting as a shallow open ulcer..."		. Completion date: May 16, 2014	

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	3. During an interview on 04/29/14 at 3:15 P.M. the DON (Director of Nursing) indicated pressure relieving interventions should have been initiated after Resident #6 and/or Resident #8 were identified as being at risk for the development of pressure. The DON further indicated, at that time, no documentation could be provided to indicate pressure relieving interventions had been initiated for Resident #6 and/or Resident #8 until after areas of pressure developed. An undated Policy and Procedure for Pressure Ulcers provided by the ADON on 04/28/14 at 3:48 P.M. indicated, "...An individual care plan will be...implemented to address...residents at risk for pressure ulcers..."			
F000323 SS=D	3.1-40(a)(1) 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. Based on observation, interview, and record review, the facility failed to ensure a side rail was safe, in that, a gap within the side rail system exceeded 4 and 3/4 inches with the potential for entrapment of head, neck, and/or limbs for 1 of 15 residents who utilized side rails in the facility census of 43. (Resident #44) Findings include:	F000323	F – 323 The corrective action taken for those residents found to be affected by the deficient practice is that Resident #44 side rail was immediately replaced on 4/23/14 to ensure resident was safe and the gap was with in the side rail system. The side rail in question was disposed of. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* All	05/16/2014

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	During an observation on 04/23/14 at 2:20 P.M., Resident #44 was observed lying in a bed with closed eyes. A half side rail was observed to be located on the upper half of the right side of the bed with a gap greater than 4 and 3/4 inches in length and width. During an interview on 04/23/14 at 2:22 P.M., the HFA (Health Facility Administrator) indicated the family of Resident #44 had provided the bed and the side rail would be changed immediately. The HFA was observed, at that time, to measure the side rail gap and indicated during an interview the gap was 7 inches (length) by 7 inches (width) and should not be greater than 4 and 3/4 inches. During an interview on 04/23/14 at 3:59 P.M., a family member of Resident #44 indicated the bed and side rail had been brought to the facility on or about January 1, 2014 and further indicated the family did not consider the side rail gap a problem because Resident #44 did not move around in the bed. The record of Resident #44 was reviewed on 04/29/14 at 9:51 A.M. The record indicated the diagnoses of Resident #44 included, but were not limited to, dementia-lewy body and vascular with behaviors and CVA (Cerebrovascular Accident) (stroke)-1999. The most recent Quarterly MDS (Minimum Data Set Assessment) dated 01/22/14 indicated Resident #44 experience moderate cognitive impairment, experienced functional impairment on the bilateral upper and lower extremities, and required extensive assist of two staff for bed mobility.		residents that utilize side rails have the potential to be affected. New Side rail assessment was completed on all residents to ensure safety and compliance with the side rail system. Individual care plans and C.N.A. assignment sheets were updated were updated accordingly. Side rail assessment will be completed quarterly and if any outside beds are purchased other than by the facility they will be assessed using the side rail system. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that Facility policy was updated regarding ensuring a side rail was safe, in that , a gap with in the side rail system does not exceed4 and ¾ inches. All nursing staff was in serviced on May 8, 2014 and on May 14th,2014 *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Side rail audit has been developed to ensure that proper procedure is being following ensuring safety of all resident using side rails continues to meet the side rail system. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance	

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	The CNA Assignment Sheet provided by the DON (Director of Nursing) on 04/23/14 at 10:50 A.M. indicated Resident #44 utilized a half side rail on the right side of the bed, and required the assist of two for repositioning in the bed. The Policy and Procedure for Bed Safety provided by the HFA on 04/29/14 at 2:56 P.M. indicated, "...To try to prevent deaths/injuries from the beds and related equipment (including...side rails...), the facility shall promote the following approaches:...b. Review that gaps within the bed system are within the dimensions established by the FDA (Food and Drug Administration)..." 3.1-45(a)(1)		meeting to determine if additional action is warranted.. Completion date: May 16, 2014	
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically			

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	contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure medications ordered were necessary, in that, an antibiotic ordered was resistive to bacteria cultured in a resident's urine (Resident #34) for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #34) Findings include: On 4/23/14 at 2:17 P.M., Resident #34 was observed in bed, napping at intervals. On 4/29/14 at 1:09 P.M., Resident #34's record was reviewed. Her diagnoses included, but were not limited to, schizoeffective disorder, cardiovascular accident, dementia, and bipolar mood disorder. A nursing note dated 4/22/14 at 7:00 A.M., indicated, "Res (resident) has dark foul smelling urine. MD notified et N. (new) O. (order) received to obtain a UA (urinalysis) c (with) C& S (culture and sensitivity) if indicated..." A nursing note dated 4/23/14 at 2:50 A.M., indicated, " UA (urinalysis) obtained et lab notified..." A urinalysis report dated 4/22/14, included but was not limited to abnormal results of leukocytes 3+ (normal range-negative), nitrite- positive (normal range- negative), protein-trace (normal range-negative),	F000329	F – 329 The corrective action taken for those residents found to be affected by the deficient practice is that Resident # 34's physician was notified on April 30, 2014 of C&S results. Physician stated NNO regarding C&S d/t too few colonies to treat or reculture. Care plan was updated accordingly. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* All residents having labs completed have the potential to be affected. All labs will remain on clip board @ nurse's station and reported daily to the physician until a response is obtained. A telephone order will be written on all labs according to the physician response. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that Facility policy was updated regarding tracking and reporting labs. All nursing staff was in serviced on May 8, 2014 and on May 14, 2014. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Lab tracking audit has been developed to ensure that medication ordered was necessary for labs reported. This tool will be completed by the DON/designee weekly for three	05/16/2014

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	blood-trace (normal range-negative),WBC (White Blood Count) >(greater than) 100 (normal range 0-2), Bacteria-many, and (normal range-none seen). A nursing note dated 4/23/14 at 6:15 P.M., indicated, "N. (new) O. (order) Rec'd (received) et noted for Bactrim D S 1 po (orally) BID (twice a day) x 5 days for UTI (urinary tract infection)..." A released urine culture record dated 4/25/14, indicated the bacteria, Proteus mirabillis had been cultured in the urine culture. The report also indicated the medication, Bactrim was resistant to the cultured bacteria, Proteus mirabillis. On 4/29/14 at 3:15 P.M., the Director of Nursing (DON) was made aware the urine culture report indicated the antibiotic medication, Bactrim was resistant to the bacteria, Proteus mirabillis. The DON at that time reviewed the urine culture report and indicated the medication, Bactrim was resistive to the bacteria, Proteus mirabillis. She indicated the physician would be notified for possible further orders. On 4/29/14 at 3:20 P.M., during interview with LPN #4, she indicated the 5 day supply of Bactrim had been completed as ordered.		weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.. Completion date: May 16 , 2014	
F000441 SS=D	3.1-48(a)(4) 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			

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	and infection. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure proper hand washing was performed, in that, proper hand washing was not performed before a nurse (RN #2) administered a respiratory treatment to a resident (Resident #23) and	F000441	F – 441 The corrective action taken for those residents found to be affected by the deficient practice is that RN # 2 and LPN # #4 were counseled on 5-2-14 on following proper hand washing prior to preforming a procedure. *The corrective action taken for the other residents having the potential to be affected by the*	05/16/2014

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	before a nurse (LPN #4) administered an insulin injection to a resident (Resident #39) according to facility policy for 2 of 6 residents observed during the medication administration. Findings include: 1. On 4/28/14 at 8:55 A.M., Resident #23 returned from a hall bathroom and was assisted by RN #2 to sit down in his recliner. Resident #23 was administered a pill of Coreg (an anti-hypertension medication) 12.5 mg while sitting in his recliner. RN # 2 then checked the resident's oxygen saturation, pulse and blood pressure. She removed the respiratory appliance tubing from a plastic bag at the bedside and set up the respiratory treatment equipment and tubing. The medication solution Duoneb (a bronchodilator medication) 2.5-0.5 mg, 1 vial was then inserted into the respiratory mask appliance. The mask was applied to Resident #23 and the respiratory treatment then started. RN #2 was observed not to perform hand washing before preparation the nebulizer treatment and administering the medication. On 4/28/14 at 2:55 P.M., the Director of Nursing (DON), provided a policy (un dated) entitled "Name of Skill: Hand -held Nebulizer Treatment". She indicated the facility policy was used for all facility respiratory treatments. The policy included but was not limited to: "...4. The nurse instructs the resident as to what she is going to do and assists the resident to a comfortable sitting position. 5. The nurse proceeds to wash her hands... 6. The nurse takes the hand-held nebulizer canister and inserts the medication and assembles the equipment and places it on a clean surface (Clean paper towel or		*same deficient practice is that* All residents are at risk for developing infection related to this deficit practice. All Nurses were in serviced on May 14, 2014 and a return demonstrated audit was completed for hand washing, insulin administration and HHN procedures. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that Facility policy was updated regarding Procedure of administration of insulin, HHN treatment and hand washing. All nursing staff was in serviced on May 8, 2014 and on May 14th, 2014 *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Skill audit tool has been developed to ensure that proper procedure is being followed while administering HHN tx and Insulin. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 16, 2014	

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	clean hand towel)..." On 4/28/14 at 3:20 P.M., the DON was made aware of lack of hand washing in regard to preparation and administration of Resident #23's breathing treatment. The DON indicated, at that time, there was a lack of hand washing before preparation of the respiratory treatment. 2. On 4/28/14 at 11:37 A.M., Resident #39 was observed sitting in her room. Her diagnoses included, but were not limited to, pneumonia and situational depression. Resident #39's April 2014 medications included, but were not limited to, "...HUMALOG (a fast-acting insulin) 100 UNITS/ML (milliliter) VIAL INJECT 21 u (units) SUB-Q (subcutaneous) WITH BREAKFAST, INJECT 18 u WITH LUNCH, AND INJECT 15 u SUB-Q AT SUPPER..." On 4/28/14 at 11:37 A.M., LPN #4 indicated she was going to administer Resident #39's noon insulin. She indicated she had not begun preparation to administer the insulin. She indicated she had checked the sliding scale insulin order and Resident #39 was to receive no sliding scale insulin at noon. She indicated Resident #39 was to receive 18 units of Humalog insulin and drew up the insulin from the Humalog vial. Then, LPN #4 entered the resident's room and closed the window blind. She then applied gloves and administered the insulin injection without hand washing. On 4/28/14 at 2:55 P.M., the Director of Nursing (DON) provided a facility policy entitled, "Subcutaneous Injections (no date)."			

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	"...Steps in the procedure: 1. Perform hand antisepsis. 2. Put on gloves. 3. Place the equipment on the bedside stand or over bed table. Arrange the supplies so that they can be easily reached. 4. Select the appropriate injection site..." On 4/28/14 at 3:20 P.M., the DON was made aware of the lack of hand washing before preparation and administering of Resident #39's noon insulin. The DON indicated at that time there had been a lack of hand washing in regard to preparation and administration of insulin. 3.1-18(l)			