

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/02/2014
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NAME OF PROVIDER OR SUPPLIER NORWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 N NORWOOD RD HUNTINGTON, IN 46750
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit resulted in an Extended Survey - Immediate Jeopardy.</p> <p>Survey dates: August 25, 26, 27, 28 and 29, 2014.</p> <p>Extended survey dates: September 2, 2014</p> <p>Facility number: 000463 Provider number: 155444 AIM number: 100290910</p> <p>Survey team: Angela Selleck, RN-TC Deborah Barth, RN (8/29/14) Shelley Reed, RN Jason Mench, RN</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 6 Medicaid: 42 Other: 5 Total: 53</p>	F000000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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

TITLE

(X6) DATE

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

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F000279 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 11, 2014, by Janelyn Kulik, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop comprehensive care plan regarding the resident refusal of daily weights and the administration of insulin for 1 of 5 residents reviewed for unnecessary medications. (Resident #11)</p>	F000279	<p>1. The care plan for resident # 11 was updated to reflect continued refusals of medication and daily weights.</p> <p>2. The facility will update the care plan of all residents who refuse medication and weights.</p>	10/02/2014

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	<p>Findings include:</p> <p>1. The clinical record of Resident #11 was reviewed on 8/27/14 at 9:10 a.m. The record indicated the resident's diagnoses included, but were not limited to, diabetes mellitus type II, chronic kidney disease, edema, encephalopathy, hypertension, atrial fibrillation, open wound(s) (multiple), and kidney transplant.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 4/25/14, indicated Resident #11 was cognitively intact. The medication administration indicated insulin was given 7 days per week and was ordered to be given 7 days per week.</p> <p>The August 2014 Physician rewrite orders included the following:</p> <p>a. "weigh daily...to monitor weight...original order date: 2/22/14..."</p> <p>b. "Humalog 100 unit/ml (milliliter) subcutaneous solution. Inject by subcutaneous route 4 times per day...(per) insulin sliding scale...(to) monitor: blood sugar...original order date 2/22/14..."</p> <p>1a. A review of the July and August 2014 "Resident Medication</p>		<p>3. Licensed staff will be re-educated to update resident care plans for medication and weight refusals. MDS coordinator/designee will monitor compliance through routine MDS completion quarterly.</p> <p>4. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter.</p> <p>5. Date of Compliance: 10/2/14</p>				

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	<p>Administration Record..." provided by the Minimum Data Set Coordinator on 8/26/14 at 5:24 p.m., indicated Resident #11 refused daily weights for the following dates in July and August 2014:</p> <p>7/2/14 7/4/14 7/5/14 7/11/14 7/12/14 7/14/14 7/16/14 7/19/14 7/22/14 7/23/14 7/29/14 7/30/14 8/4/14 8/5/14 8/9/14 8/10/14 8/12/14 8/13/14 8/15/14 8/17/14 8/18/14 8/19/14 8/20/14 8/23/14 8/24/14 8/25/14 8/26/14</p>			

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	<p>Resident #11 refused daily weights a total of 27 times from 7/1/14 through 8/26/14.</p> <p>1b. A review of the July and August 2014 "Resident Medication Administration Record..." provided by the Minimum Data Set Coordinator on 8/26/14 at 5:24 p.m., indicated Resident #11 refused the administration of Humalog insulin for the following dates in July and August 2014:</p> <p>7/21/14 at 4:00 p.m. 7/22/14 at 4:00 p.m. 7/24/14 at 4:00 p.m. 7/29/14 at 8:00 a.m. 8/1/14 at 8:00 a.m. 8/1/14 at 8:00 p.m. 8/15/14 at 12:00 p.m.</p> <p>Resident #11 refused the administration of Humalog insulin per sliding scale a total of 7 times from 7/1/14 through 8/26/14.</p> <p>A review of Resident #11's current care plans indicated there was no care plan related to the resident's refusal of daily weights or administration of insulin.</p> <p>During an interview with CNA #6 and CNA #7 on 9/2/14 at 10:17 a.m., they indicated Resident #11 will at times refuse daily weights and it depends on the resident's mood.</p>			

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F000280 SS=D	<p>During an interview with the Assistant Director of Nursing on 9/2/14 at 3:18 p.m., she indicated her and the Social Service Director both were unable to find a care plan related to Resident #11's refusals of daily weights and administration of insulin at times.</p> <p>The ADON provided a care plan titled "Refusing medications and/or treatments -potential for.." dated 9/2/14 that was initiated by the Nurse Consultant for the following problems:</p> <p>a. "...Resident will occasionally refuse medications and/or treatments.</p> <p>b. Resident has the potential to refuse medications and/or treatments.</p> <p>c. Resident sometimes refuses blood sugars or weights..."</p> <p>No further information was presented at exit on 9/2/14 at 4:50 p.m.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to</p>						

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	<p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to update the plan of care related to Preadmission Screening and Annual Resident Review (PASRR) services for 1 of 1 resident (Resident #2) reviewed for PASRR and catheter irrigation and care for 1 of 1 resident (Resident #74) reviewed for urinary catheter use.</p> <p>1. The clinical record of Resident #2 was reviewed on 8/28/14 at 3:12 p.m. The record indicated the resident's diagnoses included, but were not limited to, intellectual disability.</p> <p>On 8/29/14 at 2:15 p.m., Resident #2 was observed to be in bed asleep, holding a doll.</p> <p>On 9/2/14 at 10:22 a.m., Resident #2 was</p>	F000280	<p>1. The care plan for resident #2 was updated to include frequency of PASRR services provided. Resident #74's care plan was updated to include catheter irrigation and catheter care.</p> <p>2. The facility reviewed all residents with recommendations for PASRR services and updated the care plan as appropriate. No other issues were identified. The facility reviewed all resident with catheters to ensure catheter irrigation and catheter care was present and updated as appropriate.</p> <p>3. Licensed staff was re-educated to update the care plans of residents with catheters with irrigation orders and to provide catheter care. SS was re-educated to update the care plan for residents with PASRR services. MDS</p>	10/02/2014

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	<p>observed to be seated in her room, in her wheelchair, holding a doll.</p> <p>Review of the current Annual Minimum Data Set (MDS) assessment dated 11/1/13, indicated Resident #2 was severely cognitively impaired.</p> <p>Review of a current care plan dated 2/28/13 and updated 9/2/14, indicated Resident #2 received outside services at least 3 x monthly. The interventions included, but were not limited to, provide 1:1 visits and invite to music programs or sing along.</p> <p>During an interview on 8/29/14 at 2:30 p.m., the Social Service Director (SSD) indicated the resident received outside services and left the facility every Friday. She was asked to provide documentation to the dates the resident left the facility. At 2:55 p.m., the SSD indicated the outside service company had not been documenting when they took the resident out of the facility.</p> <p>On 9/2/14 at 9:00 a.m., the SSD indicated the outside service company had not been providing PASRR services as often as ordered because they were short staffed. She indicated the care plan would be updated today on 9/2/14.</p>		<p>coordinator/designee will monitor compliance with catheter care plans through routine MDS completion quarterly. SS/designee will monitor the care plan for residents receiving specialized services monthly for 90 days then quarterly thereafter.</p> <p>4. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter.</p> <p>5. Date of Compliance: 10/2/14</p>				

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	<p>During review of the "Monthly Objective Worksheet", provide by the SSD on 9/2/14 at 9:00 a.m., the worksheet indicated Resident #2 was provided PASRR services on July 18, 2014 and August 22, 2014.</p> <p>2. The clinical record for Resident #74 was reviewed on 8/26/14 at 8:11 a.m. Diagnoses for the resident included, but were not limited to, retention of urine, open wound and sepsis. A Quarterly Minimum Data Set (MDS) assessment dated 5/1/14, indicated the resident was cognitively intact. During review of the current physician orders, Resident #74 had an order for a Foley catheter for neurogenic bladder and urinary retention. The Foley catheter was to be irrigated with Acetic Acid 0.25%, 30 ml (milliliters) daily. Review of a current care plan dated 2/19/14 and revised May 2014, the resident had a problem with high risk for urinary tract infection related to an indwelling catheter. Approaches to this problem included, but were not limited to, provide catheter care every shift, provide thorough perineal hygiene care and empty catheter drainage collection bag every shift. The care plan did not list any daily irrigation for the urinary catheter. During an interview on 8/25/14 at 2:36</p>						

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F000282 SS=D	<p>p.m., LPN #5 indicated occasionally the resident would irrigate his own catheter and sometimes he would let the staff irrigate the catheter. She indicated she did not know if the resident had been taught to self-irrigate his catheter. 3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure residents with Preadmission Screening and Annual Resident Review (PASRR) services (Resident #2), bowel monitoring program (Resident #67) indwelling catheter care (Resident #74) and pressure ulcer treatments (Resident #11) receive those services as ordered by the physician and/or care plan.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #2 was reviewed on 8/28/14 at 3:12 p.m. The record indicated the resident's diagnoses included, but were not limited to, intellectual disability.</p>	F000282	<p>1. SS contacted Pathfinders for resident #2 to determine scheduled frequency for services as recommended by PASRR. Resident #67 BM record was reviewed and interventions implemented as appropriate. Resident #74 CNA plan of care was updated to reflect catheter care. Resident #11 treatment times were changed to include BID treatment on 8/27/14.</p> <p>2. The facility reviewed all residents with PASRR recommendations to ensure services were being provided as recommended. Resident #2 is the only resident receiving specialized services at this time. The facility reviewed all residents BM records to ensure residents were having BM's</p>	10/02/2014

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	<p>On 8/29/14 at 2:15 p.m., Resident #2 was observed to be in bed asleep, holding a doll.</p> <p>On 9/2/14 at 10:22 a.m., Resident #2 was observed to be seated in her room, in her wheelchair, holding a doll.</p> <p>Review of the current Annual Minimum Data Set (MDS) dated 11/1/13, indicated Resident #2 was severely cognitively impaired.</p> <p>Review of a current care plan dated 2/28/13 and updated 9/2/14, indicated Resident #2 received outside services at least three times per month. The interventions included, but were not limited to, provide 1:1 visits and invite to music programs or sing along.</p> <p>During an interview on 8/29/14 at 2:30 p.m., the Social Service Director (SSD) indicated the resident received outside services and left the facility every Friday. She was asked to provide documentation to the dates the resident left the facility. At 2:55 p.m., the SSD indicated the outside service company had not been documenting when they took the resident out of the facility.</p> <p>On 9/2/14 at 9:00 a.m., the SSD indicated the outside service company had not been</p>		<p>at least every 3 days and implemented interventions as appropriate. The facility reviewed all residents with catheters to ensure catheter care was present on the CNA plan of care and updated as appropriate. The facility reviewed all residents with pressure ulcers to ensure treatment orders were scheduled as ordered and update as appropriate.</p> <p>3. SS was re-educated to providing residents with PASRR recommendations the services recommended. Licensed staff was re-educated to monitor resident BM frequency and implement interventions when a resident does not have a BM timely. Nursing staff was re-educated on completing catheter care. On 8/27/14, licensed staff was re-educated on completing treatments as ordered. SS/designee will meet with the staff from Pathfinders during the first scheduled outing of the month to assure the schedule remains as is with no changes for the month. DON/designee will monitor compliance with BM monitoring 5 times weekly for 1 month, 2 times weekly for 1 month then weekly thereafter. DON/designee will monitor compliance with catheter care 3 times week for 2 weeks, 1 time per week for 2 weeks then monthly thereafter. DON/designee will monitor that treatment orders are transcribed correctly 5 x weekly.</p>	

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	<p>providing PASRR services as often as ordered because they were short staffed. She indicated the care plan would be updated today on 9/2/14.</p> <p>During review the the "Monthly Objective Worksheet", provide by the SSD on 9/2/14 at 9:00 a.m., the worksheet indicated Resident #2 was provided PASRR services on July 18, 2014 and August 22, 2014.</p> <p>2. The clinical record for Resident #67 was reviewed on 8/28/14 at 10:50 a.m. Diagnoses included, but were not limited to, cerebral artery occlusion, aphasia, hemiplegia, lower limb amputation, subdural hematoma, anxiety, depressive disorder and acute kidney disease.</p> <p>Review of the most recent Annual MDS dated 7/2/14, indicated Resident #67 was severely cognitively impaired.</p> <p>Review of a current care plan dated 8/12/13 and updated 7/14/14, indicated Resident #67 was incontinent of bowel 2 or more times per week. Interventions to this problem included, but were not limited to, monitor and record bowel and bladder patterns each shift and regularly assess bowel and bladder status and management programs.</p>		<p>4. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter.</p> <p>5. Date of Compliance: 10/2/14</p>				

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	<p>During review of the bowel elimination record for Resident #67 from June 1-August 21, 2014, Resident #67 did not have a recorded bowel movement from August 4-7th, July 28-August 1, July 17-July 20, June 29-July 3, June 18-June 27 and June 6-June 9th.</p> <p>During review of the "Alert Report", provided by the visiting Director of Nursing on 8/29/14 at 2:00 p.m., reports were generated on 6/9/14, 6/16/14, 7/2/14, 7/20/14 and 7/30/14 for lack of bowel movement greater than 3 days. The resolution only gave information that a bowel movement was noted on the following days but did not indicate what action was taken for the resident to achieve a bowel movement.</p> <p>During an interview on 8/29/14 at 2:30 p.m., the visiting Director of Nursing indicated that it appeared staff were not implementing their policy related to bowel elimination and only charting when the resident had a bowel movement. She indicated the staff had a protocol to follow after 3 days without a bowel movement that included providing a medication to relieve constipation.</p> <p>Review of a current facility policy revised 10/11, titled "COVENANT CARE STANDARD Managing Change</p>				

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	<p>of Condition " which was provided by the visiting Director of Nursing on 8/29/14 at 2:00 p.m., included, but was not limited to, the following:</p> <p>"Objective: To appropriately assess...</p> <p>...Signs & Symptoms C's ...constipation-Non-Immediate (Notify the attending or on-call MD, NP, or PA no later than the next work day) less than 1 BM in a week.</p> <p>3. The clinical record for Resident #74 was reviewed on 8/26/14 at 8:11 a.m. Diagnoses for the resident included, but were not limited to, retention of urine, open wound, necrotizing fasciitis, and sepsis. A Quarterly Minimum Data Set (MDS) assessment dated 5/1/14, indicated the resident was cognitively intact. Review of a current care plan dated 4/19/14, the resident had a problem with high risk for urinary tract infection related to an indwelling catheter. Approaches to this problem included, but were not limited to, provide catheter care every shift, provide thorough perineal hygiene care and empty catheter drainage collection bag every shift. During review of the current "Treatment</p>			

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	<p>Administration Record" (TAR) from February 7-July 25/14, the TAR did not indicate catheter care to be provided every shift.</p> <p>During an interview on 9/2/14 at 9:28 a.m., the Director of Nursing (DoN) indicated the resident was not provided with appropriate catheter care because it was not listed on his treatment record. Review of a current facility policy dated 4/07 and revised 6/12, titled " COVENANT CARE STANDARD Continance Maintenance Program " which was provided by the Administrator on 8/29/14 at 8:30 a.m., included, but was not limited to, the following: ... "Continance Maintenance Program / Indwelling Catheter Use</p> <p><u>PURPOSE:</u> To ensure that indwelling catheter ...</p> <p><u>POLICY:</u> It is the policy of Covenant Care to ensure adequate indications exist for indwelling catheter use and that appropriate treatment and services are provided to prevent infection, promote dignity, and comfort while catheterized.</p> <p><u>PROCEDURE:</u> 1. Resident will be assessed upon admission ...</p>			

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	<p>...4. Appropriate care will be provided to residents with catheters, including; *Daily catheter care and perineal hygiene ... "</p> <p>4. The clinical record for Resident #11 was reviewed on 8/27/14 at 9:10 a.m. The record indicated the resident's diagnoses included, but were not limited to, anemia, diabetes mellitus type II, open wound site, peripheral vascular disease, septicemia, iron deficiency anemia, and, history of nutrition deficiency.</p> <p>A review of Resident #11's current physician orders indicated the following:</p> <p>"Wash open wound on coccyx daily with baby magic soap. Apply dressing as directed: 1 gram gent/50 milliliters Dakin's solution/ 1 Liter NS (normal saline) - moist NOT wet gauze pack lightly to sacrum BID (twice daily). Original order date of 08/08/2014."</p> <p>A review of Resident #11's August Medication Administration Record provided by the MDS Coordinator on 8/26/14 at 5:15 p.m. indicated the following:</p> <p>a. "...1.) Wash open wound on coccyx daily with baby magic soap. 2.) Apply dressing as directed: 1 gram gent (gentamycin)/50 milliliters Dakin's</p>						

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	<p>solution/ 1 liter NS (normal saline) - Moist NOT wet gauze pack lightly to sacrum BID (twice daily). Start date: 08/08/2014 12:02 a.m."</p> <p>A review of the treatments completed to the coccyx indicated the time period of 8/8/14 through 8/26/14 only one day (8/10/14) of the 19 days was the treatment completed as ordered BID. The treatment was completed one time daily for 18 of the 19 days.</p> <p>During an interview with Resident #11 on 8/26/14 at 3:53 p.m., he indicated the nurse was to do his treatment to his coccyx twice daily, morning and night, but the treatment had not been completed yet that day and has only been completed once a day for awhile now and he was unsure why that was.</p> <p>A review of Resident #11's care plan for pressure ulcer and wound infection indicated the following:</p> <p>a. "Rewritten 5/20/14...Actual Pressure Ulcer ... site coccyx dated 7/13... Goal: Wound(s) will show signs of improvement x 90 days. No signs or symptoms of infection x 90 days...</p> <p>...Interventions: Assess pressure ulcer weekly by licensed nurse...</p>			

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	<p>Treatment Ordered: Cleanse with baby shampoo, rinse with N.S.(normal saline), apply Gent/Dakins moistened gauze to coccyx BID (twice daily)..."</p> <p>The initial care plan for actual pressure ulcers was dated 7/31/13 and indicated Resident #11 required two person assist with turning and repositioning.</p> <p>b. ..."Wound Infection. Location: Coccyx... Evidenced by:... + (positive cultures including VRE (Vancomycin-Resistant Enterococci)... Wound tx (treatment) with Gent/Dakins solution as ordered.</p> <p>A review of a progress note from the wound clinic dated 8/7/14 provided by the Admissions Director on 8/26/14 at 5:30 p.m. indicated the following:</p> <p>a. "...History of Present Illness... Location of wound: coccyx and right ischial tuberosities...7-13-14 cx (culture) growing 4 bacteria including VRE and other drug resistant organisms. On bactrim but is scheduled to see ID (infectious disease) at my request to NH (nursing home) made previously...</p> <p>b. ..."Plan: ...Wash wound daily with baby magic soap...1 gram gent/50 ml</p>			

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	<p>Dakin's solution/ 1 liter NS - Moist not wet gauze pack lightly to sacrum bid... ...8-7-14 CALL NURSING HOME AND FIND OUT WHAT IS GOING ON WITH THE ID (Infectious Disease) CONSULT FOR POLYMICROBIAL INFECTION OF WOUND INCLUDING VRE."</p> <p>During an interview with the Nurse Consultant on 8/27/14 at 4:02 p.m., she indicated based on the documentation on the August 2014 medication administration record Resident #11 did not receive the treatment as ordered to his coccyx. The Nurse Consultant indicated there had been some breaks where skin measurements were not completed weekly. She indicated until around two weeks ago there was not one specific person designated to complete wound measurements and assessments. The ADON was currently designated to completed wound measurements and assessments weekly.</p> <p>The Nurse Consultant indicated the Infectious Disease Consult was not scheduled and the consult recommendation was just seen on 8/25/14. She indicated she was unable to find any documentation for referral of Infectious Disease from the wound clinic that was mentioned on 7/31/14 in the</p>			

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F000309 SS=D	<p>progress note from the wound clinic dated 8/7/14.</p> <p>A review the policy "Covenant Care Skin Integrity Standard" updated June 2010 provided by the Nurse Consultant on 8/27/14 at 4:30 p.m. indicated the following:</p> <p>"Practice: Residents identified to be at risk for skin breakdown (pressure ulcers) will have a routine assessment...</p> <p>...Procedure:.. Weekly "head to toe assessment of all residents by Licensed nurse with narrative documentation of findings..."</p> <p>No further information was presented at exit on 9/2/14 at 4:50 p.m.</p> <p>3.1-35(g)(1) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to</p>	F000309	1. The NP was notified on	10/02/2014			

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	<p>provide the correct medication related to wound care for 1 of 35 residents reviewed. (Resident #74).</p> <p>Findings include:</p> <p>The clinical record for Resident #74 was reviewed on 8/26/14 at 8:11 a.m. Diagnoses for the resident included, but were not limited to, necrotizing fasciitis, gangrene, diabetes mellitus, retention of urine, open wound and sepsis. During review of the current Treatment Administration Record (TAR) dated 8/5/14, the following treatments were ordered by the wound clinic: Left scrotal area-clean wound and peri wound with soap and water. Rinse with normal saline. Vashe (wound cleanser) moist to dry as primary dressing, then cover with Army Battle Dressing (ABD) and Kerlix (gauze). Change twice daily x 1 week. Buttock-clean wound and peri wound with soap and water. Rinse with normal saline. Vashe (wound cleanser) moist to dry as primary dressing, then cover with Army Battle Dressing (ABD) and Kerlix (gauze). Change twice daily x 1 week. Review of current facility order dated 8/17/14, indicated the current treatment to the buttock area was Dakins (a solution to kill and prevent wound infections) 1/2 strength. The order</p>		<p>8/25/14 and the MD was notified on 8/26/14 of the resident receiving normal saline as a treatment for 2 days. No other orders were noted. The facility obtained Dakin's solution on evening of 8/25/14.</p> <p>2. The facility reviewed resident treatment orders to ensure medication was available. No other issues were identified.</p> <p>3. Licensed staff was re-educated to provide treatments as ordered and to notify the MD if desired treatment was not available and obtain alternative orders. DON/designee will monitor compliance through random treatment reviews 5 times weekly for 2 weeks, 3 times weekly for 2 weeks then weekly thereafter.</p> <p>4. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter.</p> <p>5. Date of Compliance: 10/2/14</p>	

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	<p>indicated to pack open wounds of buttock/peri area with moist (not wet) roll gauze twice daily, then cover with border foam dressing.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated 5/1/14, indicated the resident was cognitively intact.</p> <p>Review of a current care plan dated 2/1914, revised 8/14, the resident had a problem with risk for complications related to debridement. Approaches to this problem included, but were not limited to, monitor for pain and administer medications as ordered and monitor for s/s of infection.</p> <p>During an interview on 8/25/14 at 2:26 p.m., Resident #74's sister indicated the resident did not feel well related to a 103 degree temperature.</p> <p>During an interview on 8/25/14 at 3:12 p.m., the resident indicated the facility ran out Dakin's last Thursday.</p> <p>During an interview on 8/25/14 at 3:00 p.m., LPN #5 indicated the only wound treatment done on 8/25/14 was with the normal saline because the facility ran out of Dakin's solution. She indicated the physician had not been notified.</p> <p>During an interview on 8/26/14 at 3:00 p.m., LPN #2 indicated the facility ran out of Vashe and she looked at the back of the bottle and thought it was the same ingredients as Dakins. She indicated she then put the Dakins order into the system</p>			

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	<p>without a physician's order or calling the pharmacy for a refill.</p> <p>During observation on 8/26/14 at 5:00 p.m., LPN #3 and LPN #8 removed the old dressing, applied 1/2 strength Dakin's solutions to Kerlix gauze and packed in the coccyx wound and then covered with Opti-foam dressing.</p> <p>Review of a Nurse's note date 8/26/14, the physician was notified the resident ran out of Dakin's solution 2 days ago and had only been receiving normal saline. A late entry dated 8/25/14, indicated the Nurse Practitioner was notified the resident had not received Dakin's for the past two days.</p> <p>Review of a current facility policy dated 12/1/07 and revised 5/1/10 and 1/1/13, titled " General Dose Preparation and Medication Administration " which was provided by the Director of Nursing on 9/2/14 at 2:07 p.m., included, but was not limited to, the following:</p> <p>"Applicability: This policy 6.0 sets forth...</p> <p>...4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:</p> <p>4.1 Facility staff should:</p> <p>4.1.1 Verify each time a medication is</p>						

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F000314 SS=J	<p>administered that it is the correct medication... ...4.1.2 Confirm that the MAR reflects the most recent medication order;...</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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. Based on observation, interview and record review, the facility failed to prevent progress of a pressure ulcer resulting in a stage 4 with bone visible and failed to provide treatment as prescribed twice daily to the coccyx area for 1 of 4 residents reviewed for pressure. (Resident #11) In addition to the resident in immediate jeopardy, the facility failed to ensure a resident with pressure areas received proper skin treatments in accordance with his plan of care resulting in the potential for harm that is not an immediate jeopardy for 1 of 4 residents reviewed for pressure. (Resident #40)</p>	F000314	<p>1. Resident #11 coccyx/sacrum wound was measure 8/20/14 and again on 8/27/14, his regularly scheduled wound day. The assessment revealed the wound had changed in as much that slough was no longer present and bone was now visible which demonstrates progression of healing per the NPUAP guidelines. An SBAR was completed at that time. The wound MD was contacted on 8/27/14 regarding the change in resident #11 wound. Resident #11 treatment orders were reviewed the evening of 8/27/14 and updated to reflect the scheduled frequency of</p>	10/02/2014

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	<p>The Immediate Jeopardy began on 8/8/14 when the facility failed to provide treatment as prescribed twice daily to the coccyx area. The Administrator, Interim Director of Nursing, Visiting Director of Nursing and the Nurse Consultant were notified of the immediate jeopardy on 8/27/14. The Immediate Jeopardy was removed on 8/29/14 but the noncompliance remained at the lower scope and severity with no actual harm but potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings included:</p> <p>1. The clinical record of Resident #11 was reviewed on 8/27/14 at 9:10 a.m. Diagnoses for the resident included, but were not limited to, anemia, diabetes mellitus type II, open wound site, anxiety, depressive disorder, kidney transplant, transplant status organ, status amputee above knee, peripheral vascular disease, septicemia, iron deficiency anemia, tobacco use, aftercare organ transplant, history of nutrition deficiency and malignant neoplasm kidney.</p> <p>During an observation on 8/27/14 at 10:51 a.m. with LPN #1 present the ADON (Assistant Director of Nursing) measured the coccyx pressure ulcer of</p>		<p>administration. The wound MD was notified on 8/28/14 of resident receiving daily treatments not twice daily treatments as ordered. On 8/26/14, the wound MD was informed of the missed Infectious Disease referral. Resident #11 was seen by the Infectious Disease MD on 9/11/14 with no new orders noted. Resident #40 no longer resides in the facility.</p> <p>2. The facility reviewed MD orders for residents with pressure ulcers to ensure transcription accuracy on 8/27/14 and updated as appropriate. On 8/25/14, the facility audited MD progress notes, MD consult notes, and nurse's notes from 7/1/14-8/25/14 validating all outside MD referrals had been scheduled. On 8/27/14, the facility reviewed all other residents with pressure ulcers to ensure weekly wound measurements were present. The facility reviewed all residents with pressure ulcers to ensure treatments were completed as ordered.</p> <p>3. Licensed staff were re-educated on completing a change of condition SBAR for new skin conditions and completing the initial pressure ulcer form. Licensed staff was trained on staging of pressure ulcers and appearance of wounds. Licensed staff was trained to review consult sheets and schedule MD referrals with physician's, specialist, or clinics upon return and/ or after referrals</p>				

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	<p>Resident #11. The ADON indicated the pressure ulcer was a stage 4 measuring 4.4 cm long by 3.9 cm wide by 2.1 cm deep with an area measuring 2.3 cm long by 1.8 cm of visible bone. The ADON indicated the pressure area did not have visible bone on the last wound assessment she had completed on 8/20/14. The ADON indicated the pressure ulcer had worsened.</p> <p>A review of Resident #11's MDS (Minimum Data Set) OBRA (Omnibus Budget Reconciliation Act) Quarterly Review dated 4/25/14 indicated the resident was cognitively intact and required extensive assistance and two plus person physical assistance with bed mobility, transfers and toileting.</p> <p>A review of the "Pressure Ulcer Evaluation Records," indicated the following measurements for the coccyx pressure ulcer:</p> <p>a. On 7/31/13 the coccyx pressure ulcer was a stage 3 measuring 6 cm long by 5.4 cm wide by 0.4 cm deep. This was the initial admission assessment and measurement of the pressure ulcer.</p> <p>b. On 6/2/14 the coccyx pressure ulcer was a stage 3 measuring 6.4 cm long by 4.2 cm wide by 2.8 cm deep.</p>		<p>were made. Licensed staff was trained to accurately transcribe new orders as prescribed by physician. Licensed staffs were trained to complete treatments per MD order. DON/designee will monitor weekly that wound measurements are completed timely. DON/designee will monitor that MD orders are transcribed correctly 5 x a week. Medical Records/designee will monitor that MD referrals are scheduled timely 5 x week. ADON/designee will monitor treatments are completed for resident with pressure ulcers 5 x week. 4. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter. 5. Date of Compliance: 10/2/14</p>		

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	<p>c. No "Pressure Ulcer Evaluation Record" was provided for week of June 9, 2014.</p> <p>d. On 6/18/14 the coccyx pressure ulcer was a stage 4 measuring 6.5 cm long by 5.0 cm wide by 2.0 cm deep.</p> <p>e. On 6/23/14 the coccyx pressure ulcer was a stage 4 measuring 6.0 cm long by 4.8 cm wide by 3.5 cm deep.</p> <p>f. On 6/30/14 the coccyx pressure ulcer was a stage 4 measuring 6.7 cm long by 4.3 cm wide by 3.5 cm deep.</p> <p>g. No "Pressure Ulcer Evaluation Record" was provided for week of July 7, 2014.</p> <p>h. On 7/14/14 the coccyx pressure ulcer was a stage 4 measuring 5.2 cm long by 3.8 cm wide by 2.0 cm deep.</p> <p>i. No "Pressure Ulcer Evaluation Record" was provided for week of July 21, 2014.</p> <p>j. On 7/28/14 the coccyx pressure ulcer was a stage 4 measuring 5.0 cm long by 3.7 cm wide by 2.4 cm deep.</p> <p>k. No "Pressure Ulcer Evaluation</p>			

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	<p>Record" was provided for week of August 4, 2014.</p> <p>l. On 8/11/14 the coccyx pressure ulcer was a stage 4 measuring 4.8 cm long by 3.7 cm wide by 2.0 cm deep.</p> <p>m. On 8/14/14 the coccyx pressure ulcer was a stage 4 measuring 5.2 cm long by 3.8 cm wide by 2.4 cm deep.</p> <p>n. On 8/20/14 the coccyx pressure ulcer was a stage 4 measuring 4.5 cm long by 3.5 cm wide by 2.0 cm deep.</p> <p>A review of Resident #11's current physician orders indicated the following:</p> <p>1. "Wash open wound on coccyx daily with baby magic soap. Apply dressing as directed: 1 gram gent/50 milliliters Dakin's solution/ 1 Liter NS (normal saline) - moist NOT wet gauze pack lightly to sacrum BID (twice daily). Original order date of 08/08/2014."</p> <p>A review of Resident #11's August Medication Administration Record provided by the MDS Coordinator on 8/26/14 at 5:15 p.m. indicated the following:</p> <p>a. "...1.) Wash open wound on coccyx daily with baby magic soap. 2.) Apply</p>						

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	<p>dressings as directed: 1 gram gent (gentamycin)/50 milliliters Dakin's solution/ 1 liter NS (normal saline) - Moist NOT wet gauze pack lightly to sacrum BID (twice daily). Start date: 08/08/2014 12:02 a.m."</p> <p>A review of the treatments completed to the coccyx indicated the time period from 8/8/14 through 8/26/14 only one day (8/10/14) of the 19 days was the treatment completed as ordered BID. The treatment was completed one time daily for 18 of the 19 days.</p> <p>During an interview with Resident #11 on 8/26/14 at 3:53 p.m., he indicated the nurse was to do his treatment to his coccyx twice daily, morning and night, but the treatment had not been completed yet that day and had only been completed once a day for awhile now and he was unsure why that was.</p> <p>A review of Resident #11's care plan for pressure ulcer and wound infection indicated the following:</p> <p>a. "Rewritten 5/20/14...Actual Pressure Ulcer ... site coccyx dated 7/13... Goal: Wound(s) will show signs of improvement x 90 days. No signs or symptoms of infection x 90 days...</p>			

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	<p>...Interventions: Assess pressure ulcer weekly by licensed nurse...</p> <p>Treatment Ordered: Cleanse with baby shampoo, rinse with N.S.(normal saline), apply Gent/Dakins moistened gauze to coccyx BID (twice daily)..."</p> <p>The initial care plan for actual pressure ulcers was dated 7/31/13 and indicated Resident #11 required two person assist with turning and repositioning.</p> <p>b. ..."Wound Infection. Location: Coccyx... Evidenced by:... + (positive cultures including VRE (Vancomycin-Resistant Enterococci)... Wound tx (treatment) with Gent/Dakins solution as ordered.</p> <p>A review of a progress note from the wound clinic dated 8/7/14 provided by the Admissions Director on 8/26/14 at 5:30 p.m. indicated the following:</p> <p>a. "...History of Present Illness... Location of wound: coccyx and right ischial tuberosities...7-13-14 cx (culture) growing 4 bacteria including VRE and other drug resistant organisms. On bactrim but is scheduled to see ID (infectious disease) at my request to NH (nursing home) made previously..."</p>			

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	<p>b. "...Plan: ...Wash wound daily with baby magic soap...1 gram gent/50 ml Dakin's solution/1 liter NS - Moist not wet gauze pack lightly to sacrum bid... ..8-7-14 CALL NURSING HOME AND FIND OUT WHAT IS GOING ON WITH THE ID (Infectious Disease) CONSULT FOR POLYMICROBIAL INFECTION OF WOUND INCLUDING VRE."</p> <p>During an interview with the Nurse Consultant on 8/27/14 at 4:02 p.m., she indicated according to the documentation on the August 2014 medication administration record Resident #11 did not receive the treatment as ordered to his coccyx. The Nurse Consultant indicated there have been some breaks where skin measurements were not being completed weekly. She indicated until around two weeks ago there was not one specific person designated to complete wound measurements and assessments. The ADON is currently designated to complete wound measurements and assessments weekly.</p> <p>The Nurse Consultant indicated the Infectious Disease Consult was not scheduled and the consult recommendation was just seen on 8/25/14. She indicated she was unable to find any documentation for referral of</p>						

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	<p>Infectious Disease from the wound clinic that was mentioned on 7/31/14 in the progress note from the wound clinic dated 8/7/14.</p> <p>2. The closed clinical record of Resident #40 was reviewed on 8/28/14 at 2:20 p.m. Diagnoses for the resident included, but were not limited to, stage 3 pressure ulcer to the coccyx and left buttock, malignant neoplasm, paraplegia, hypertension, polyneuropathy, fracture of the femur and lumbago.</p> <p>The initial pressure ulcer evaluation record, dated 5/26/14, indicated the first wound was noted on the coccyx. The wound measured 2.6 cm x 2.4 cm x <0.1 cm. The wound was staged as a stage 3 wound.</p> <p>The second wound was noted on 5/27/14 to the right buttocks. The wound measured 1.0 cm x 0.4 cm x 0.1 cm. The wound was staged as a stage 3 wound.</p> <p>The physician order for treatment of the wound to the coccyx, dated 5/28/14, indicated the wound was to be covered with Maxorb Ag (antimicrobial wound dressing). The dressing was to be changed daily and as needed.</p> <p>The physician order for treatment of the wound to the right buttocks, dated 6/6/14,</p>			

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	<p>indicated the wound was to be covered with Maxorb Ag (antimicrobial wound dressing). The dressing was to be changed three times per week.</p> <p>During review of the Medication Administration Record (MAR), provided by the Administrator on 8/30/14 at 8:30 a.m., the record indicated dressing changes on 6/4/14, 6/7/14 and 6/8/14. The MAR showed 33 missing dressing changes to the coccyx.</p> <p>During review of the Medication Administration Record (MAR), provided by the Administrator on 8/30/14 at 8:30 a.m., the record indicated dressing was last changed on 6/13/14. The resident was discharged on 6/20/14.</p> <p>During an interview on 8/28/14 at 2:50 p.m., the Director of Nursing was made aware of the missing dressing changes. No additional information was provided.</p> <p>A current health care plan problem dated 5/25/14, indicated an actual pressure ulcer. The interventions for the problem included, but were not limited to, check dressing placement every shift and monitor for s/s of infection daily-increased warmth of surrounding tissue redness, swelling, pain, purulent drainage, foul odor.</p>			

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F000315 SS=G	<p>No additional information was provided related to dressing change dates and times.</p> <p>The immediate jeopardy that began on 8/8/14 was removed on 8/29/14 when the facility re-educated the nurses on pressure ulcer care and developed a pressure ulcer monitoring tool. The nurses were interviewed and confirmed learning of the education on pressure ulcer care and the monitoring tool was reviewed., But the noncompliance remained at the lower scope and severity level of no actual harm but potential for more than minimal harm that is not immediate jeopardy.</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. Based on interview and record review,</p>	F000315	1. Resident #74 CNA plan of	10/02/2014

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	<p>the facility failed to prevent urinary tract infections by providing catheter care for 1 of 3 residents reviewed (Resident #74) This deficient practice resulted in multiple oral, intramuscular and intravenous antibiotic use for the resident. (Resident #74)</p> <p>Findings include: The clinical record for Resident #74 was reviewed on 8/26/14 at 8:11 a.m. Diagnoses for the resident included, but were not limited to, necrotizing fasciitis, gangrene, diabetes mellitus, retention of urine, colostomy, open wound, and sepsis. During review of the current physician orders, Resident #74 had an order for a Foley catheter for neurogenic bladder and urinary retention. The Foley catheter was to be irrigated with Acetic Acid 0.25%, 30 ml daily. During review of the current Treatment Administration Record (TAR) from February 7-July 25/14, the TAR did not indicate catheter care to be provided every shift. A Quarterly Minimum Data Set (MDS) assessment dated 5/1/14, indicated the resident was cognitively intact. Review of a current care plan dated 2/1914, the resident had a problem with high risk for urinary tract infection related to an indwelling catheter.</p>		<p>care was updated to reflect frequency catheter care. 2. The facility reviewed all residents with catheters to ensure frequency catheter care was included in the nursing assistant plan of care. 3. Nursing staff was re-educated to complete catheter care according the to residents plan of care. DON/designee will monitor compliance with catheter care 3 times week for 2 weeks, 1 time per week for 2 weeks then monthly thereafter. 4. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter. 5. Date of Compliance: 10/2/14</p>	

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	<p>Approaches to this problem included, but were not limited to, provide catheter care every shift, provide thorough perineal hygiene care and empty catheter drainage collection bag every shift.</p> <p>Review of the current Medication Administration Record (MAR), the following antibiotic were given to treat urinary tract infections:</p> <p>4/4/14- Ampicillin (an antibiotic used treat bacterial infections) 500 mg daily for 10 days.</p> <p>4/18/14-Ceftriaxone (an antibiotic used treat bacterial infections) 1 gram x 3 days.</p> <p>4/21/14- Levofloxacin (an antibiotic used treat bacterial infections) 750 mg x 10 days.</p> <p>4/22/14- Doxycycline (an antibiotic used treat bacterial infections) 100 mg twice daily x 10 days.</p> <p>5/18/14- Cephalexin (an antibiotic used treat bacterial infections) 1000 mg twice daily x 10 days.</p> <p>6/20/14-Gentamicin (an antibiotic used treat bacterial infections) 120 mg/100 ml, give 160 ml intravenous x 4 days.</p> <p>6/20/14-Gentamicin 120 mg/100 ml, give 160 ml intravenous three times daily x 7 days.</p> <p>8/26/14-Ampicillin 500 mg three times daily x 10 days.</p> <p>8/26/14-Ceftriaxone 1 gram intramuscular x 1 dose.</p>			

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	<p>8/10/14- Ceftriaxone 1 gram intramuscular daily x 6 doses.</p> <p>8/9/14-Ceftriaxone 1 gram intramuscular x 1 dose.</p> <p>During review of the laboratory results, Resident #74 had a urinalysis on 4/2/14 that culture grew >100,000 orgs/ml Escherichia coli.</p> <p>On 5/17/14, a culture grew multiple organisms isolated suggesting possible catheter colonization with positive nitrates and 2+ moderate leukocytes.</p> <p>On 6/13/14, Resident #74 grew >100,000 orgs/ml Citrobacter youngae and >100,000 orgs/ml Escherichia coli with 3+ leukocytes and positive nitrates.</p> <p>On 8/8/14, a urine culture indicated >100,000 orgs/ml Proteus mirabilis with 1+ leukocyte and positive nitrates.</p> <p>On 8/23/14, Resident #74 had a urinalysis with leukocyte 2+ moderate and cloudy appearance.</p> <p>During observation on 8/25/14 at 2:26 p.m., Resident #74's Foley catheter bag was noted on the floor.</p> <p>During an interview on 8/25/14 at 2:26 p.m., Resident #74 indicated he did not feel well and his sister indicated he had a temperature over 103 degrees. She indicated they were waiting to see if they would be taking him to the hospital since he just finished an antibiotic and Tylenol did not seem to bring down his temperature. The resident indicated he</p>						

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	<p>put the Foley bag on the floor and staff had made attempts to hook the Foley bag to the side of the bed.</p> <p>During an interview on 8/25/14 at 2:36 p.m., LPN #5 indicated she was unsure if the resident was provided self catheter care, but stated he would sometimes do his own catheter care. She indicated the Nurse Practitioner (NP) just gave a new order for Rocephin 1 gram to be given.</p> <p>During an interview on 9/2/14 at 9:28 a.m., the Director of Nursing (DoN) indicated the resident was not provided with appropriate catheter care.</p> <p>Review of a current facility policy dated 4/07 and revised 6/12, titled " COVENANT CARE STANDARD Contenance Maintenance Program " which was provided by the Administrator on 8/29/14 at 8:30 a.m., included, but was not limited to, the following:</p> <p>... " Contenance Maintenance Program / Indwelling Catheter Use</p> <p><u>PURPOSE:</u> To ensure that indwelling catheter ...</p> <p><u>POLICY:</u> It is the policy of Covenant Care to ensure adequate indications exist for indwelling catheter use and that appropriate treatment and services are provided to prevent infection, promote dignity, and comfort while catheterized.</p>			

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F000353 SS=E	<p><u>PROCEDURE:</u></p> <p>1. Resident will be assessed upon admission ...</p> <p>...4. Appropriate care will be provided to residents with catheters, including; *Daily catheter care and perineal hygiene ... "</p> <p>3.1-37(a)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to provide sufficient</p>	F000353		10/02/2014	

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	<p>nursing and CNA staff to meet the needs of residents related to providing basic care to the residents who reside in the facility.</p> <p>Findings include:</p> <p>During an interview on 8/28/14 at 4:03 p.m., CNA #9, indicated the staff had worked short every shift. She indicated she worked 6 days a week by picking up on her days off because the facility only had four evening shift CNA's. CNA #9 indicated most CNA's worked double shifts most days. She indicated the nurses worked short every shift also. She indicated the short staffing had been going on for at least a year and a half and most days were worked with 3 CNA's on day and evening shifts and many shifts just 2 CNA's. She indicated they did not get their work done and the residents and their charting suffered. CNA #9 indicated when they worked short, they had to complete the care of the Residents which required the assist of two people together and during that time the call lights have stayed on for long periods of time.</p> <p>During an interview on 8/28/14 at 4:54 p.m., CNA #10 indicated they worked short every shift. They were supposed to have 4 CNA's scheduled for evening shift and they usually only had 3 and</p>		<ol style="list-style-type: none"> The facility closed down one wing to consolidate residents and assist facility staff to better care for residents. Facility department managers interviewed a sampling of alert and oriented residents to ensure sufficient staff to answer call lights. The DON/designee will review staffing patterns daily for all three shifts to ensure adequate staffing present to meet resident needs. The facility will monitor compliance through daily schedule reviews and random resident interviews 5 x weekly for 1 month, 3 x weekly for 1 month, and monthly thereafter. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter. Date of Compliance: 10/2/14 	

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	<p>sometimes they had worked with 2 CNA's. She indicated the CNA's were mandated to work over on night shift many nights until the facility decided they only needed 2 CNA'S on night shift. She indicated they were unable to get their work done and the residents and their charting suffered. CNA #10 indicated when they worked short they had to complete the care of the residents who required the assist of two people together and the call lights had stayed on for long periods of time.</p> <p>During an interview on 8/28/14 at 5:00 p.m., CNA #14 indicated they worked short every shift and only had four CNA's for evening shift. She indicated they usually worked with 3 CNA's on day and evening shift and sometimes they only worked with 2 CNA's. She indicate she was mandated to work over on nights almost every shift until the facility told them they only needed 2 CNA's on night shift. She indicated she did not think this was safe because they had so many residents that were 2 assists. When this happened they worked together to get those residents taken care of, but the call lights stayed on for long periods of time because they could not get to them. She indicated she had worked at least 5 evenings a week.</p>			

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	<p>During an interview on 8/28/14 at 5:10 p.m., CNA #13 indicated he had only worked here a short time and had worked short most evenings he had worked. They normally worked with 3 CNA's and had worked with only 2 CNA's on one occasion. He indicated they were unable to get their work done when they had worked short.</p> <p>During an interview on 8/28/14 at 5:20 p.m., LPN #3 indicated the staff worked short every shift. The staff was told one nurse per hall was adequate, but she was working over every shift to catch up on charting and helping the CNA's. She worked 12 hour shifts to 16 hour shifts 5 days a week on average due to being called in on her days off, usually on night shift. Every part of her work suffered due to working short and working so many hours.</p> <p>During an interview on 8/29/14 at 4:55 p.m., LPN #4 indicated she was getting ready to end her shift and only 2 nurses would be working the floor until 6:30 p.m. when another nurse was due to arrive to fill in.</p> <p>During an interview on 9/2/14 at 8:39 a.m., Resident #24, indicated to be cognitively intact on a Minimum Data Set (MDS) assessment completed on</p>				

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	<p>7/18/14, indicated he has had to wait up to an hour to have his call light answered on many occasions and he felt that a person could die in this place and no one would know for awhile because of how little they check on residents. He indicated there had been many times when only one CNA was working their hall and they had to wait their turn.</p> <p>During an interview on 9/2/14 at 8:50 a.m., Resident #38, indicated to be cognitively intact on an MDS assessment completed on 6/20/14, indicated she had to wait up to an hour at times to get call lights answered and they usually waited 20 to 30 minutes to get answered on a normal basis. She indicated she had seen only one CNA working her hall on many occasions.</p> <p>During an interview on 9/2/14 at 10:30 a.m., the Health Information Manager indicated the facility staffed according to census. They only took into consideration the level of acuity of the residents if they had a specific reason to. The facility tried to staff 3 to 5 CNA's on day shift, 3 to 4 CNA's on evening shift and 2 to 3 CNA's on night shift. Day shift and evening shift were staffed with 3 nurses and night shift was staffed with 2 nurses. She indicated they have had problems with staffing for the last 6 months, with July, 2014 being a</p>						

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	<p>very difficult month. She indicated the facility even called other facilities in their Corporation to have staff come and help, but the staff did not show up.</p> <p>During an interview on 9/2/14 at 11:00 a.m., the Health Information Manager and Administrator indicated they were aware they had multiple employees working over 16 hour shifts in a 24 hour period on multiple occasions.</p> <p>Review of the last 4 months of " Daily Nursing Department Schedule " sheets, provided on 8/29/14 at 8:00 a.m., indicated 2 nurses were assigned to the day shift on the following dates: 7/10/14 and 7/26/14. Two and a half nurses were assigned on 7/25/14. Three CNA's were assigned on 7/10/14, 7/25/14 and 8/23/14. During the evening shift 2 CNA's were assigned on 7/5/14 and 7/21/14. Two and a half CNA ' s were assigned on 7/8/14. Three CNA's were assigned on 7/19/14 and 7/20/14. During the night shift 1.5 nurses were assigned to work on 7/6/14. Two CNA's were assigned to work on 5/7/14, 6/24/14, 6/25/14, 6/29/14 and 7/3/14. Two evening " Daily Nursing Department Schedule " sheets were undated and indicated on one evening 2.5 CNA's and 1.5 nurses were scheduled to work and one night shift " Daily Nursing</p>						

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F000441 SS=F	<p>Department Schedule " sheet was undated and indicated one night nurse was scheduled.</p> <p>Review of the Resident Census and Conditions of Residents indicated 53 residents required the assist of one or two staff for bathing, 49 residents required the assist of one or two staff for dressing, 46 residents required the assist of one or two for transferring, 48 residents required the assist of one or two for toilet use and 51 residents required the assist of one or two for eating. One resident was completely dependent on staff for transferring and one resident was completely dependent on staff for eating.</p> <p>3.1-17(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program</p>			
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	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility isolation precautions were maintained with the facility staff for 1 of 1 resident in isolation for Vancomycin-Resistant Enterococci (VRE) and failed to ensure a consult with Infectious Disease per Wound Clinic recommendation. (Resident #11) The facility failed to ensure soiled linens, trash and biohazard were handled and</p>	F000441	<p>1. The facility implemented contact isolation procedures for resident #11. The nursing staff was re-educated regarding contact isolation for VRE on 9/2/14. On 8/26/14, the wound MD was informed of the missed Infectious Disease referral. Resident #11 was seen by the Infectious Disease MD on 9/11/14 with no new orders noted. The Infection Control log was</p>	10/02/2014			

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	<p>disposed of to prevent the spread of infection and the facility failed to track and trend potential infections in regard to maintaining a complete and accurate infection control book. This failure had the potential to affect 53 of 53 residents who resided in the facility.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> The clinical record of Resident #11 was reviewed on 8/27/14 at 9:10 a.m. Diagnoses for the resident included, but were not limited to, anemia, diabetes mellitus type II, open wound site, anxiety, depressive disorder, kidney transplant, transplant status organ, status amputee above knee, peripheral vascular disease, septicemia, iron deficiency anemia, tobacco use, aftercare organ transplant, history of nutrition deficiency and malignant neoplasm kidney. <p>During an observation of Resident #11's room on 8/25/14 at 3:00 p.m. with LPN #4, a red stop sign was observed on the door "Stop, check with nurse before entering," no biohazard containers were in the room, no gloves or isolation gowns were observed inside or outside of resident's room.</p> <p>During an observation on 8/26/14 at 1:15 p.m. of Resident #11's room, a biohazard</p>		<p>completed to include tracking and trending of infections for June to the present. The pillow and pillowcase was placed in an appropriate container in the soiled utility room. The carts in the soiled utility room were rearranged to allow easy access to the biohazard cabinet. The plastic bag was removed from the floor of the soiled utility room and placed in an appropriate container.</p> <ol style="list-style-type: none"> No other residents were in isolation precautions. On 8/25/14, the facility audited MD progress notes, MD consult notes, and nurse's notes from 7/1/14-8/25/14 validating all outside MD referrals had been scheduled. The facility placed a taped area outside the biohazard cabinet in the soiled utility to prevent barrels from being placed in front of the door. The Infection Control log was reviewed and updated as appropriate. Facility staff were re-educated on infection control procedures for residents in isolation including communication of residents in isolation, supplies required for isolation, proper procedures to care for residents in isolation, and proper procedures for disposing of trash and proper handling of linens. Facility staff was re-educated on procedures for keeping the barrels away from the door to the biohazard cabinet and to place linen and trash in appropriate containers. 	

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	<p>container was observed but no gloves or gowns were observed.</p> <p>During an interview with LPN #1 on 8/25/14 at 2:47 p.m., she indicated Resident #11 was in isolation for an infection of the wound on his coccyx. She indicated Resident #11 had a roommate. LPN #1 indicated she did not use isolation gowns when entering Resident #11's room or when providing care or treatments to the resident's wounds. She indicated she only used hand washing and gloves for isolation precautions. LPN #1 indicated Resident #11 did not need to be in a private room while he was in isolation.</p> <p>During an observation and interview with LPN #1 and the Assistant Director of Nursing (ADON) on 8/27/14 at 10:51 a.m., LPN #1 indicated there was a moderate amount of drainage and a visible shadow was observed on the outside of the bandage to the right hip prior to the removal of the bandage during a wound treatment that was provided at that time.</p> <p>During an wound treatment observation on Resident #11 with LPN #1 and the ADON on 8/27/14 at 11:39 a.m., LPN #1 walked out of Resident #11's room with isolation gown on into the hallway and to</p>		<p>DON/designee will monitor compliance with infection control practices for residents in isolation through random observations 3 x weekly for 2 weeks, 2 x weekly for 2 weeks, then weekly thereafter. Observations to include: appropriate supplies and room set-up, staff appropriate use of needed supplies, proper disposal of trash and linen handling. Housekeeping supervisor will monitor compliance with the soiled utility through observations of the soiled utility room 5 x weekly for 2 weeks, 3 x weekly for 2 weeks then weekly thereafter. ED/designee will monitor compliance with Infection Control Log completion through observation monthly.</p> <p>4. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter.</p> <p>5. Date of Compliance: 10/2/14</p>	

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	<p>the treatment cart to retrieve a pair of scissors. LPN #1 then re-entered Resident #11's room with the same isolation gown on.</p> <p>During an interview on 8/27/14 at 3:06 p.m. with LPN #3 and a Visiting Director of Nursing (D.o.N), LPN #3 indicated she was the nurse for Resident #11's roommate on 8/27/14 but not for Resident #11. LPN #3 indicated she was not aware what the red stop sign on Resident #11 and his roommate's door was for.</p> <p>During an observation 8/28/14 at 2:40 p.m., CNA #9 brought one medium size bag of linen and one small bag of trash that were in clear plastic trash bags outside of Resident #11 room. CNA #10 removed the Hoyer lift and blue sling from Resident #11's room that was used to weigh the resident. The blue sling was laying on top of the Hoyer lift.</p> <p>During an interview with CNA #9 and CNA #10, the CNA's indicated they were unaware what to do with soiled linen and soiled trash from Resident #11's room. They indicated they were only told Resident #11's soiled wound bandages go in the red biohazard container that was in the room. CNA #9 and CNA #10 indicated there was no place to put the</p>			

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	<p>soiled laundry in Resident #11's room.</p> <p>During an observation and interview on 8/28/14 at 2:50 p.m., the Visiting D.o.N. educated CNA #9 and CNA #10 on isolation contact procedures. She indicated to the CNA's to wear an isolation gown, gloves and to wash hands. She indicated there needed to be a laundry biohazard container in Resident #11's room and not to bring trash or linen outside of the room. The Visiting D.o.N. indicated the soiled trash and linen needed to be in biohazard bags. CNA # 9 and CNA #10 then placed the open clear plastic bags of soiled laundry and trash onto Resident #11's floor.</p> <p>During an interview with Housekeeping staff #11 on 9/2/14 at 10:30 a.m., she indicated no facility management, department heads or nurses had educated her on Resident #11's isolation precautions. She indicated she was unaware of what type of infection the resident had for isolation, what type of isolation the resident was on or even how to clean the isolation room. Housekeeping staff #11 indicated she had just heard of Resident #11 being in isolation the week of 8/25/14. She indicated there was no separate containers for linen or trash in Resident #11's room.</p>						

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	<p>Housekeeping staff #12 indicated there were no biohazard containers in Resident #11's room until the week of 8/25/14.</p> <p>During an interview with the Administrator (ADM), Interim D.o.N. and Health Information Manager on 9/2/14 at 12:10 p.m., the ADM indicated facility department heads should educate the staff throughout the facility by daily report off to each other.</p> <p>The Interim D.o.N. indicated they were notified in morning meetings of any residents on isolation and it is passed down to the department heads.</p> <p>The Health Information Manager indicated staff would need to be re-educated if they had walked out of isolation rooms with the isolation gown on.</p> <p>During an interview with the Interim D.o.N. on 9/2/14 at 2:10 p.m., she indicated staff were educated on 9/2/14 to follow contact and standard precautions for VRE isolation for Resident #11. She indicated it was optional if staff wanted to wear an isolation gown or not.</p> <p>A review of Resident #11's initial care plan for actual pressure ulcers was dated</p>			

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	<p>7/31/13 and indicated the following:</p> <p>b. ..."Wound Infection. Location: Coccyx (and) Right hip...dated 3/21/14 Evidenced by:... + (positive cultures including VRE (Vancomycin-Resistant Enterococci) dated 6/24/14...Interventions:...Contact precautions for VRE in buttock wound."</p> <p>A review of a progress note from the wound clinic dated 8/7/14 provided by the Admissions Director on 8/26/14 at 5:30 p.m. indicated the following:</p> <p>a. "...History of Present Illness... Location of wound: coccyx and right ischial tuberosities...7-13-14 cx (culture) growing 4 bacteria including VRE and other drug resistant organisms. On bactrim but is scheduled to see ID (infectious disease) at my request to NH (nursing home) made previously...</p> <p>b. ..."Plan: ...Wash wound daily with baby magic soap...1 gram gent/50 ml Dakin's solution/ 1 liter NS - Moist not wet gauze pack lightly to sacrum bid... ..8-7-14 CALL NURSING HOME AND FIND OUT WHAT IS GOING ON WITH THE ID (Infectious Disease) CONSULT FOR POLYMICROBIAL INFECTION OF WOUND INCLUDING VRE."</p>						

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	<p>During an interview with the Nurse Consultant on 8/27/14 at 4:02 p.m., she indicated the Infectious Disease Consult was not scheduled and the recommendation for consult was just seen on 8/25/14. She indicated she was unable to find any documentation for referral of Infectious Disease from the wound clinic that was mentioned on 7/31/14 in the progress note from the wound clinic dated 8/7/14.</p> <p>2. During an interview with LPN #1 on 8/25/14 at 2:47 p.m., she indicated the soiled wound dressings from Resident #11 are double bagged and placed in the red biohazard container in soiled utility room.</p> <p>During an observation of the dirty utility room with the Administrator (ADM) on 8/25/14 at 3:20 p.m. The following was observed:</p> <p>a. A white pillowcase covering a pillow was soiled with a brown substance in multiple areas on the pillowcase. The pillow and pillow case were seated on the utility sink on top of dirty bed pans.</p> <p>b. One biohazard container with a red biohazard plastic bag was located inside of a wooden cabinet with no items</p>			
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	<p>observed in the red plastic biohazard bag. The biohazard container and cabinet was blocked by a floor cart with a mop bucket sitting on top of the cart. To get to the biohazard container and cabinet, staff would need to move the four yellow plastic containers used for the soiled laundry, one gray plastic trash container, the floor cart and the mop bucket that was placed directly in front of the biohazard cabinet.</p> <p>During an observation of the soiled utility room with the Visiting D.o.N. on 8/28/14 at 3:22 p.m., the following was observed:</p> <p>a. A large open clear plastic trash bag filled with trash was placed on the floor in the soiled utility room.</p> <p>During an interview with the Visiting D.o.N., she indicated trash was in the bag placed on the floor and there should be a trash container for the trash to be placed into located in the soiled utility room but there was not.</p> <p>During an interview with the ADM on 8/25/14 at 3:25 p.m., he indicated the pillow case and pillow covered in a brown substance should not be placed in the utility sink but instead in one of the soiled laundry containers. The ADM indicated it would be difficult to get to</p>			

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	<p>the biohazard cabinet and container or even open the cabinet due to the floor cart and mop bucket located in front of the cabinet and those items would need to be moved along with the containers that blocked the passage to the biohazard cabinet.</p> <p>3. During an observation of the Infection Control log with the Interim D.o.N on 9/2/14 at 1:59 p.m., the Infection Control logs for June and July 2014 were incomplete and no log for August 2014 had been started. The Interim D.o.N was unable to determine if any trends of a particular infection in June 2014 due to system not completed.</p> <p>An interview with the Interim D.o.N. on 9/2/14 at 1:59 p.m., indicated the infection control log was not updated at this time and was not easily readable of trends or tracking of infections in the facility. She indicated there were a total of 12 urinary tract infections in June 2014 and she was unable to see if there was a trend of a particular hallway at this time because the mapping was not yet completed. The Interim D.o.N. indicated she had not started on the August 2014 Infection Control log. The Interim D.o.N. indicated she was unable to find a lot of the diagnoses or symptoms pertaining to the use of the antibiotics</p>				

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	<p>residents had used to complete the Infection Control log due to the time limit of getting the Infection Control Log together.</p> <p>During an interview with the Interim D.o.N. on 9/2/14 at 9:26 p.m., she indicated the Infection Control log for May 2014 was not completed. The Interim D.o.N. indicated pericare had not been addressed since she had been at the facility.</p> <p>4. A policy titled "Infection Prevention Manual for Long Term Care...Vancomycin -Resistant Enterococcus (VRE)" dated 2012 provided by the Visiting D.o.N. on 8/28/14 at 3:30 p.m. indicated the following:</p> <p>DESCRIPTION: ...VRE may be passed from person to person by the hands of caregivers following contact with the resident or contaminated surfaces.</p> <p>PRECAUTIONS: * Contact Precautions</p> <p>Room Considerations: * Infected or colonized residents</p>						

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F000502 SS=D	<p>should be placed in private rooms or cohorted.</p> <p>* If neither is available...a semi-private room with a low-risk roommate is acceptable...</p> <p>...REFERENCES:</p> <p>* See the CDC (Centers for Disease Control) web page...</p> <p>3.1-18(j)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to ensure labs were completed for 1 of 5 reviewed for unnecessary medications. (Resident #45)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #45 was reviewed on 8/28/14 at 3:42 p.m. Diagnoses for the resident included, but were not limited to, chronic kidney disease stage V, diabetes mellitus type II controlled, hyperpostassemia, congestive heart failure, end stage renal disease, edema, anemia, mild cognitive</p>	F000502	<ol style="list-style-type: none"> Resident # 45 labs were obtained. The facility reviewed all resident labs to ensure results were present and obtained labs where appropriate. Licensed staff was re-educated regarding obtaining labs in a timely manner. DON/designee will monitor lab orders to ensure completeness monthly. Results of the audits will be forwarded to QA&A monthly for tracking and trending for 3 months 	10/02/2014

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	<p>impairment and depressive disorder.</p> <p>Physician's orders indicated the resident had orders that included, "K+ (potassium) level and Hgb (hemoglobin) A1C (a standard tool to determine blood sugar control for patients with diabetes) on 7/21 original order date 01/17/2014... and ...potassium in 5 months, August 2014, Schedule: One-Time at 8/05/2014... original order date 03/21/2014..."</p> <p>A review of the labs completed for Resident #45 indicated no K+ level or Hgb A1C were completed on 7/21 and no K+ level was completed on 8/05/2014 as ordered.</p> <p>During an interview with the Administrator and Interim Director of Nursing (D.o.N.) on 8/29/14 at 10:12 a.m., indicated they were unable to find any labs completed on 7/21/14 for Hgb A1C or a potassium level. The Interim D.o.N. indicated there was an order for Hgb A1C and a potassium level for 7/21/14 and it was not completed.</p> <p>During an interview with the Administrator and the visiting D.o.N on 8/29/14 at 1:55 p.m., they indicated the potassium lab draw scheduled for 8/5/14 was not completed as ordered.</p>		<p>then quarterly thereafter.</p> <p>5. Date of Compliance: 10/2/14</p>				

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F000520 SS=F	<p>3.1-49(a)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to develop and implement appropriate plans of action to address treatments not being done as ordered by the physician for pressure ulcers and infection control concerns related to isolation, Infection Control Log, linen and biohazard processing as identified during the Annual</p>	F000520	<p>1. The facility developed action plans to address infection control concerns related to isolation practices, linen and biohazard processing, and completion of the Infection Control log.</p> <p>2. As stated in F 309, F 314, and F441, audits were completed to</p>	10/02/2014

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	<p>Recertification and State Licensure survey.</p> <p>Findings include:</p> <p>Interview with the Administrator on 9/2/14 at 3:00 p.m., indicated the facility's Quality Assurance Committee meets at least quarterly and consists of himself, the Director of Nursing, Assistant Director of Nursing and Health Information Manager as well as the Medical Director. The last meeting was 8/22/14.</p> <p>During an observation on 8/27/14 at 10:51 a.m. with LPN #1 present the ADON (Assistant Director of Nursing) measured the coccyx pressure ulcer of Resident #11. The ADON indicated the pressure ulcer was a stage 4 measuring 4.4 cm long by 3.9 cm wide by 2.1 cm deep with an area measuring 2.3 cm long by 1.8 cm of visible bone. The ADON indicated the pressure area did not have visible bone on the last wound assessment she had completed on 8/20/14. The ADON indicated the pressure ulcer had worsened.</p> <p>A review of Resident #11's current physician orders indicated the following:</p> <p>1. "Wash open wound on coccyx daily</p>		<p>identify other residents that may have the potential to be affected and interventions implemented as appropriate.</p> <p>3. Facility management was re-educated on the Quality Management Program (QMP) including expectations for ongoing audits to identify areas of opportunity, development of action plans to correct issues identified, and monitoring progress of completion with action items.</p> <p>4. The facility will continue to utilize the QMP as a way to review facility systems to ensure processes are in place and develop action plans to correct issues identified during routine QA audits. Results of audits and outstanding QA action plans will be reviewed during QA&A monthly until substantial compliance is achieved.</p> <p>5. Date of Compliance: 10/2/14</p>	

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	<p>with baby magic soap. Apply dressing as directed: 1 gram gent/50 milliliters Dakin's solution/ 1 Liter NS (normal saline) - moist NOT wet gauze pack lightly to sacrum BID (twice daily). Original order date of 08/08/2014."</p> <p>A review of Resident #11's August Medication Administration Record provided by the MDS Coordinator on 8/26/14 at 5:15 p.m. indicated the following:</p> <p>a. "...1.) Wash open wound on coccyx daily with baby magic soap. 2.) Apply dressing as directed: 1 gram gent (gentamycin)/50 milliliters Dakin's solution/ 1 liter NS (normal saline) - Moist NOT wet gauze pack lightly to sacrum BID (twice daily). Start date: 08/08/2014 12:02 a.m."</p> <p>A review of the treatments completed to the coccyx indicated the time period from 8/8/14 through 8/26/14 only one day (8/10/14) of the 19 days was the treatment completed as ordered BID. The treatment was completed one time daily for 18 of the 19 days.</p> <p>During an interview with Resident #11 on 8/26/14 at 3:53 p.m., he indicated the nurse was to do his treatment to his coccyx twice daily, morning and night,</p>			

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	<p>but the treatment had not been completed yet that day and had only been completed once a day for awhile now and he was unsure why that was.</p> <p>During an interview with the Nurse Consultant on 8/27/14 at 4:02 p.m., she indicated according to the documentation on the August 2014 medication administration record Resident #11 did not receive the treatment as ordered to his coccyx. The Nurse Consultant indicated there have been some breaks where skin measurements were not being completed weekly. She indicated until around two weeks ago there was not one specific person designated to complete wound measurements and assessments. The ADON is currently designated to complete wound measurements and assessments weekly.</p> <p>The clinical record of Resident #11 was reviewed on 8/27/14 at 9:10 a.m. Diagnoses for the resident included, but were not limited to, anemia, diabetes mellitus type II, open wound site, anxiety, depressive disorder, kidney transplant, transplant status organ, status amputee above knee, peripheral vascular disease, septicemia, iron deficiency anemia, tobacco use, aftercare organ transplant, history of nutrition deficiency and malignant neoplasm kidney.</p>			

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	<p>During an observation of Resident #11's room on 8/25/14 at 3:00 p.m. with LPN #4, a red stop sign was observed on the door "Stop, check with nurse before entering," no biohazard containers were in the room, no gloves or isolation gowns were observed inside or outside of resident's room.</p> <p>During an observation on 8/26/14 at 1:15 p.m. of Resident #11's room, a biohazard container was observed but no gloves or gowns were observed.</p> <p>During an interview with LPN #1 on 8/25/14 at 2:47 p.m., she indicated Resident #11 was in isolation for an infection of the wound on his coccyx. She indicated Resident #11 had a roommate. LPN #1 indicated she did not use isolation gowns when entering Resident #11's room or when providing care or treatments to the resident's wounds. She indicated she only used hand washing and gloves for isolation precautions. LPN #1 indicated Resident #11 did not need to be in a private room while he was in isolation.</p> <p>During an observation and interview with LPN #1 and the Assistant Director of Nursing (ADON) on 8/27/14 at 10:51 a.m., LPN #1 indicated there was a</p>			

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	<p>moderate amount of drainage and a visible shadow was observed on the outside of the bandage to the right hip prior to the removal of the bandage during a wound treatment that was provided at that time.</p> <p>During an wound treatment observation on Resident #11 with LPN #1 and the ADON on 8/27/14 at 11:39 a.m., LPN #1 walked out of Resident #11's room with isolation gown on into the hallway and to the treatment cart to retrieve a pair of scissors. LPN #1 then re-entered Resident #11's room with the same isolation gown on.</p> <p>During an interview on 8/27/14 at 3:06 p.m. with LPN #3 and a Visiting Director of Nursing (D.o.N), LPN #3 indicated she was the nurse for Resident #11's roommate on 8/27/14 but not for Resident #11. LPN #3 indicated she was not aware what the red stop sign on Resident #11 and his roommate's door was for.</p> <p>During an observation 8/28/14 at 2:40 p.m., CNA #9 brought one medium size bag of linen and one small bag of trash that were in clear plastic trash bags outside of Resident #11 room. CNA #10 removed the Hoyer lift and blue sling from Resident #11's room that was used</p>			

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	<p>to weigh the resident. The blue sling was laying on top of the Hoyer lift.</p> <p>During an interview with CNA #9 and CNA #10, the CNA's indicated they were unaware what to do with soiled linen and soiled trash from Resident #11's room. They indicated they were only told Resident #11's soiled wound bandages go in the red biohazard container that was in the room. CNA #9 and CNA #10 indicated there was no place to put the soiled laundry in Resident #11's room.</p> <p>During an observation and interview on 8/28/14 at 2:50 p.m., the Visiting D.o.N. educated CNA #9 and CNA #10 on isolation contact procedures. She indicated to the CNA's to wear an isolation gown, gloves and to wash hands. She indicated there needed to be a laundry biohazard container in Resident #11's room and not to bring trash or linen outside of the room. The Visiting D.o.N. indicated the soiled trash and linen needed to be in biohazard bags. CNA # 9 and CNA #10 then placed the open clear plastic bags of soiled laundry and trash onto Resident #11's floor.</p> <p>During an interview with Housekeeping staff #11 on 9/2/14 at 10:30 a.m., she indicated no facility management, department heads or nurses had educated</p>			

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	<p>her on Resident #11's isolation precautions. She indicated she was unaware of what type of infection the resident had for isolation, what type of isolation the resident was on or even how to clean the isolation room.</p> <p>Housekeeping staff #11 indicated she had just heard of Resident #11 being in isolation the week of 8/25/14. She indicated there was no separate containers for linen or trash in Resident #11's room.</p> <p>Housekeeping staff #12 indicated there were no biohazard containers in Resident #11's room until the week of 8/25/14.</p> <p>During an interview with the Administrator (ADM), Interim D.o.N. and Health Information Manager on 9/2/14 at 12:10 p.m., the ADM indicated facility department heads should educate the staff throughout the facility by daily report off to each other.</p> <p>The Interim D.o.N. indicated they were notified in morning meetings of any residents on isolation and it is passed down to the department heads.</p> <p>The Health Information Manager indicated staff would need to be re-educated if they had walked out of isolation rooms with the isolation gown</p>			
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	<p>on.</p> <p>During an interview with the Interim D.o.N. on 9/2/14 at 2:10 p.m., she indicated staff were educated on 9/2/14 to follow contact and standard precautions for VRE isolation for Resident #11. She indicated it was optional if staff wanted to wear an isolation gown or not.</p> <p>A review of Resident #11's initial care plan for actual pressure ulcers was dated 7/31/13 and indicated the following:</p> <p>b. ..."Wound Infection. Location: Coccyx (and) Right hip...dated 3/21/14 Evidenced by:... + (positive cultures including VRE (Vancomycin-Resistant Enterococci) dated 6/24/14...Interventions:...Contact precautions for VRE in buttock wound."</p> <p>A review of a progress note from the wound clinic dated 8/7/14 provided by the Admissions Director on 8/26/14 at 5:30 p.m. indicated the following:</p> <p>a. "...History of Present Illness... Location of wound: coccyx and right ischial tuberosities...7-13-14 cx (culture) growing 4 bacteria including VRE and other drug resistant organisms. On bactrim but is scheduled to see ID (infectious disease) at my request to NH</p>			

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	<p>(nursing home) made previously...</p> <p>b. ..."Plan: ...Wash wound daily with baby magic soap...1 gram gent/50 ml Dakin's solution/ 1 liter NS - Moist not wet gauze pack lightly to sacrum bid... ...8-7-14 CALL NURSING HOME AND FIND OUT WHAT IS GOING ON WITH THE ID (Infectious Disease) CONSULT FOR POLYMICROBIAL INFECTION OF WOUND INCLUDING VRE."</p> <p>During an interview with the Nurse Consultant on 8/27/14 at 4:02 p.m., she indicated the Infectious Disease Consult was not scheduled and the recommendation for consult was just seen on 8/25/14. She indicated she was unable to find any documentation for referral of Infectious Disease from the wound clinic that was mentioned on 7/31/14 in the progress note from the wound clinic dated 8/7/14.</p> <p>During an interview with LPN #1 on 8/25/14 at 2:47 p.m., she indicated the soiled wound dressings from Resident #11 are double bagged and placed in the red biohazard container in soiled utility room.</p> <p>During an observation of the dirty utility room with the Administrator (ADM) on</p>			

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NAME OF PROVIDER OR SUPPLIER NORWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 N NORWOOD RD HUNTINGTON, IN 46750		
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	<p>8/25/14 at 3:20 p.m. The following was observed:</p> <p>a. A white pillowcase covering a pillow was soiled with a brown substance in multiple areas on the pillowcase. The pillow and pillow case were seated on the utility sink on top of dirty bed pans.</p> <p>b. One biohazard container with a red biohazard plastic bag was located inside of a wooden cabinet with no items observed in the red plastic biohazard bag. The biohazard container and cabinet was blocked by a floor cart with a mop bucket sitting on top of the cart. To get to the biohazard container and cabinet, staff would need to move the four yellow plastic containers used for the soiled laundry, one gray plastic trash container, the floor cart and the mop bucket that was placed directly in front of the biohazard cabinet.</p> <p>During an observation of the soiled utility room with the Visiting D.o.N. on 8/28/14 at 3:22 p.m., the following was observed:</p> <p>a. A large open clear plastic trash bag filled with trash was placed on the floor in the soiled utility room.</p> <p>During an interview with the Visiting D.o.N., she indicated trash was in the bag</p>				

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	<p>placed on the floor and there should be a trash container for the trash to be placed into located in the soiled utility room but there was not.</p> <p>During an interview with the ADM on 8/25/14 at 3:25 p.m., he indicated the pillow case and pillow covered in a brown substance should not be placed in the utility sink but instead in one of the soiled laundry containers. The ADM indicated it would be difficult to get to the biohazard cabinet and container or even open the cabinet due to the floor cart and mop bucket located in front of the cabinet and those items would need to be moved along with the containers that blocked the passage to the biohazard cabinet.</p> <p>During an observation of the Infection Control log with the Interim D.o.N on 9/2/14 at 1:59 p.m., the Infection Control logs for June and July 2014 were incomplete and no log for August 2014 had been started. The Interim D.o.N was unable to determine if any trends of a particular infection in June 2014 due to system not completed.</p> <p>An interview with the Interim D.o.N. on 9/2/14 at 1:59 p.m., indicated the infection control log was not updated at this time and was not easily readable of</p>			

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	<p>trends or tracking of infections in the facility. She indicated there were a total of 12 urinary tract infections in June 2014 and she was unable to see if there was a trend of a particular hallway at this time because the mapping was not yet completed. The Interim D.o.N. indicated she had not started on the August 2014 Infection Control log. The Interim D.o.N. indicated she was unable to find a lot of the diagnoses or symptoms pertaining to the use of the antibiotics residents had used to complete the Infection Control log due to the time limit of getting the Infection Control Log together.</p> <p>During an interview with the Interim D.o.N. on 9/2/14 at 9:26 p.m., she indicated the Infection Control log for May 2014 was not completed. The Interim D.o.N. indicated pericare had not been addressed since she had been at the facility.</p> <p>Interview with the Interim Director of Nursing (DoN) on 9/2/14 at 2:10 p.m., indicated staff were educated on 9/2/14 related to standard precautions for isolation. She indicated it was optional to wear a gown.</p> <p>Interview with the Administrator on 9/2/14 at 3:15 p.m., indicated the</p>						

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	<p>pressure wound program was a work in progress because the Assistant Director of Nursing took over the program and had only been in the facility about two weeks. He indicated the facility did a house wide skin sweep that was completed on 7/16/14. He also indicated infection control monitoring related to isolation, influenza for both staff and residents, Tuberculosis screening was to be completed last Friday during the Annual Recertification. The process was not completed since the survey had started.</p> <p>3.1-52(b)(2)</p>				