

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2016
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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 25, 26, 27, 28, and 29, 2016.</p> <p>Facility number: 000186 Provider number: 155289 AIM number: 100266300</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type: Medicare: 19 Medicaid: 67 Other: 12 Total: 98</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on November 4, 2015 by 17934.</p>	F 0000		

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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F 0156 SS=B Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide residents with information to make an informed decision about appeal rights for 3 of 3 residents reviewed for Medicare discharge rights. (Resident #116, 144, and 60)</p> <p>Findings include:</p> <p>The following residents were reviewed for Medicare discharge on 4/28/16 at 9:30 a.m.:</p> <ol style="list-style-type: none"> 1. Resident # 116 was issued a discharge letter dated 3/30/16 with discharge dated for 4/1/16. The letter included appeal rights, but no financial information about charges. 2. Resident # 144 was given a letter dated 2/17/16 for discharge from Medicare services on 2/15/16. The letter was signed by the resident and included appeal information. It did not include any financial information about charges if the resident chose to have a demand bill. 3. Resident # 60 was given a letter informing her on 4/20/16 of Medicare services ending on 4/25/16. The letter included information about appeal rights, 	F 0156	<p>The facility is unable to correct the alleged deficient practice for residents # 116, 144 and 60. All residents have the potential to be affected by the alleged deficient practice. An audit will be conducted to ensure no other residents have been affected by the alleged deficient practice. MDSC/Assistant MDSC/Office Manager re-educated regarding the procedure for non-coverage of Medicare notices, all ABN and NOMNC letters. MDS Consultant to review 10 Medicare notices, ABN'S and NOMNC letters each month for 3 months. If within 100% compliance audits will be completed quarterly thereafter. Results of audits to be forwarded to the QA Committee for review.</p>	05/29/2016

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	<p>but no financial information to allow the resident to make an informed decision about demand billing.</p> <p>Interview with the Admission Coordinator, on 4/28/16 at 10 a.m., indicated the facility used to give an Advanced Beneficiary Notice of Noncoverage (ABN), but stopped somewhere after she changed jobs to become the Admissions Coordinator. She indicated the Medicare discharge notices were done by Minimum Data Set (MDS) Coordinator. The Admissions Coordinator had been the MDS Coordinator.</p> <p>Interview with the present MDS Coordinator was done on 4/29/16 at 9:12 a.m. She started on 11/2/15 as the MDS Coordinator. She indicated she had been trained for working with Medicaid, but her training had not included Medicare utilization. She indicated she gave the residents a Medicare discharge letter. She reviewed the demand billing process with the residents. She asked if they had any questions. She also indicated she had been made aware on 4/28/16 that the ABN letter was necessary.</p> <p>3.1-4(f)(3)</p>			

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to ensure physician notification of weight gain and unavailability of an antibiotic medication for 2 of 23 residents reviewed for</p>	F 0157	Nurse Practitioner has been notified of the past weight loss for resident #154 and also the delay in antibiotic therapy for resident #174. All other residents have the potential to be affected by the	05/29/2016	

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	<p>physician notification. (Resident #154 & 174)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #154 was reviewed on 4/27/16 at 1:06 p.m. Diagnoses included, but were not limited to, chronic systolic congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, primary pulmonary hypertension, edema, pleural effusion and injury of kidney.</p> <p>A review of Resident #154's current physician orders indicated the following:</p> <p>"...Weekly weight - Notify Physician of a weight gain 3 lbs. [pounds] or greater. every [Every] day shift every Thurs [Thursday] related to HEART FAILURE, UNSPECIFIED...order date...01/04/2016...."</p> <p>A review of Resident #154's "Weight Summary", dated 1/7/16 to 4/21/16, indicated the following:</p> <p>On 3/3/16 Resident #154's weight was 148.6 pounds and on 3/22/16 it was 159.4 pounds, which indicated a 10.8 pound weight gain in 19 days.</p> <p>A review of Resident #154's "Progress</p>		<p>alleged deficient practice. Weights have been reviewed for the last 90 days to ensure no other resident has been affected by the alleged deficient practice as well as any resident that has received IV antibiotic therapy within the last 90 days. Nurses to be re-educated regarding the facility policy for Physician/Family/Responsible Notification for change in condition and medication availability. QAPI/Abaqis Nurse/Weekend Manager to audit resident ordered IV antibiotics daily to ensure that appropriate notifications have occurred when applicable. Unit Manager/Designee to audit any Dr. weights to ensure that the appropriate notifications have been made 5 times a week. Results of audits to be reviewed at the monthly QA Committee meetings ongoing.</p>		

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	<p>Notes" indicated the following:</p> <p>"...3/24/2016 [at] 10:08 [a.m.] Type: Nurses Note...notified family of weight gain...</p> <p>...3/22/2016 [at] 14:47 [2:47 p.m.] Type: Dietary PN [Progress Note]...W/C [wheelchair] wt. [weight] obtained today at 159.4 # [pounds]; with significant gain noted. Will monitor.</p> <p>...4/20/2016 [at] 11:43 [a.m.] Type: Nurses note...NP [Nurse Practitioner] made aware of resident having a 16.8 pound weight gain over the past 120 days. No new orders at this time."</p> <p>No further information was provided at time of exit on 4/29/16.</p> <p>A review of a policy titled "PHYSICIAN/FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION" dated 8/2013, was provided by the Director of Nursing on 4/29/16 at 10:59 a.m. and indicated the following:</p> <p>"Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner.</p>			

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	<p>Responsibility: All Licensed Nursing Personnel</p> <p>Policy: 1. Physician and family/responsible party notification is to include, but is not limited to: ...Change in condition that may warrant a change in current treatment...</p> <p>2. Physician and Family/Responsible Party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained." Resident #174's clinical record was reviewed on 4/26/16 at 10:52 A.M. Resident #174's current diagnosis included, but was not limited to, streptococcal infection.</p> <p>Review of a document titled, "[Name of Hospital] Discharge Summary", dated 4/16/16, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., included the following: "...He was</p>			

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	<p>advised to be continued on Rocephin [an antibiotic] 1 g [gram] IV [intravenously] daily for 7 days and Vibramycin [an antibiotic] 100 mg [milligrams] IV twice a day for 7 days while in the nursing home undergoing therapy..."</p> <p>Review of Resident #174's "Medication Administration Record" for April 2016, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., indicated Resident #174 did not receive Vibramycin for two doses on 4/17/16, two doses on 4/18/16, one dose on 4/19/16, and one dose on 4/25/16.</p> <p>Review of "Progress Notes", dated from 4/17/16 through 4/25/16, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., included the following:</p> <p>"...4/17/16 10:00 [A.M.]... upon reviewing discharge note from hospital, [Name of Physician] had suggested continuing Vibramycin and Rocephin iv [sic] for 7 days for strep sanguinus [sic] found on blood culture. no orders were written to continue these meds, no iv [sic] line in place. Call placed to NP [Nurse Practitioner]... order recd [received] to continue..."</p> <p>"...4/17/16 12:00 [noon]... Will start IV antibiotics as soon as midline placed..."</p>			

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	<p>"...4/18/16 10:46 [A.M.]... Called [Name of Pharmacy] regarding IV supplies since have not received at this time. Spoke to pharmacist [Name of Pharmacist] and they do not have it in their [sic] IV department, they are working on getting this and all supplies to us..."</p> <p>Review of a document titled, "Administrative Physician's Orders", dated 1/2012, and provided by the Director of Nursing on 4/29/16 at 10:59 A.M., included the following: "...Check for any orders that require verification. The orders will be verified by the nurse and the instructions for the order will be completed..."</p> <p>During an interview with LPN #19 on 4/28/16 at 11:11 A.M., she indicated if an antibiotic was not available she would contact the physician or NP to see how they would proceed.</p> <p>During an interview with a facility NP on 4/28/16 at 11:29 A.M., he indicated a physician or NP is on-call 24/7 and should be notified if a medication, especially an IV antibiotic, was unavailable from pharmacy. He further indicated the physician or NP would determine if it would be ok to wait for the antibiotic to arrive or if another antibiotic</p>			

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F 0241 SS=E Bldg. 00	<p>would be used if the gap in treatment was too long. Furthermore, he would expect a facility nurse to call as soon as they knew an antibiotic was unavailable.</p> <p>3.1-5(a)(3)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to assure residents were treated with dignity during direct care (Resident # 50) and dining regarding having conversations around residents and moving chairs without making the resident aware. (Residents # 42, 131, 71, and 66)</p> <p>Findings include:</p> <p>1. Resident # 50 was interviewed on 4/25/16 at 2:20 p.m. He indicated the staff did not give him a chance to talk or answer choice questions. He indicated the CNAs "tell me what to do." He also</p>	F 0241	The facility is unable to correct the previous alleged deficient practice for resident #42, 50, 44, 131 and 71. Number 50's choice form has been updated. All the residents have the potential to be affected by the alleged deficient practice. All resident choice forms to be reviewed for any needed changes as well as the shower list and get up list will be revised on the Redbud/Hickory halls. Resident choices will be updated on the care plans and in the C.N.A point of care Kardex. Nursing staff to be re-educated regarding dignity and respect of individuality and changed in the shower and get up list. Choices will be reviewed upon	05/29/2016

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	<p>indicated it didn't "do any good" to tell the nurse. He indicated the staff were "too busy talking to each other" to pay attention to what he wanted. He also indicated he never chose when to get up in the morning or when to go to bed at night. He indicated he would prefer to sleep later in the morning than 7:00 a.m. when staff normally got him out of bed. He also indicated he wanted to go to bed right after supper about 7:30 p.m., but was not put to bed until around 9 p.m.</p> <p>The resident's call light was turned on at 2:40 p.m. Two CNAs responded within six minutes to the call light. They came in with a Hoyer lift and began getting the resident ready to be toileted. They did not ask him what he needed or talk to him as they entered the room. The resident resisted being transferred by pulling away. The staff then asked him if he didn't want toileted. When he replied, "No" and the staff were told the call light response was being timed, a CNA replied, "Are you going to be doing this all afternoon?" The staff then turned and left the room with the Hoyer lift.</p> <p>Resident # 50's clinical record was reviewed on 4/29/16 at 10:12 a.m. Diagnoses included, but were not limited to: depression, constipation, diabetes, chronic obstructive pulmonary disease,</p>		<p>admission and at each care plan conference. In addition the Social Services Director will review choices randomly with 8 residents weekly for 12 weeks. Results of the QA tool will be forwarded to the QA Committee for any needed follow up.</p>	

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	<p>and history of stroke.</p> <p>The care plan, dated as last reviewed on 2/10/16, indicated the resident had an adl (activities of daily living) deficit which included his inability to walk, move himself in bed, eat, dress himself, toilet himself, transfer himself, or bathe himself. His care plan indicated he had behaviors of refusing medications and care. His care plan also listed his desire to make choices for his own care. The only choice listed was that he wanted four showers per week.</p> <p>The Hickory Lane & Redbud Court 3rd Shift Get Up List was provided by Unit Manager # 1 on 4/27/16 at 1:00 p.m. The Unit Manager indicated this list told the CNAs who should be awakened and dressed before the day shift arrived at 6:00 a.m. He indicated he had recently revised the list, but no one was to be awakened before 5 a.m. The list indicated 3 of 5 residents on Redbud Court and 1 of 5 residents on Hickory Lane were to have been dressed and left in bed. When asked about this, he indicated other residents complained if they were awakened this early, so he had chosen residents who wouldn't complain. He also indicated resident choices were not indicated anywhere but on the care plan.</p>			

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	<p>During a dining observation in the therapeutic dining room, beginning on 4/25/16 at 12:14 p.m., the following was observed:</p> <p>Resident B was seated in a reclined position in his Broda chair at the dining table. Unit Manager #44 approached the resident from behind and pushed the back of his chair to an upward position without speaking to the resident.</p> <p>Resident #131 was seated in a reclined position in her Broda chair near a dining table. LPN # 52 indicated to CNA #53 that Resident #131 was asleep. CNA#53 approached the resident from behind and pushed the back of her chair to an upright position without speaking to the resident.</p> <p>CNA #53 then approached Resident #71 from behind and moved her Broda chair, repositioning it at the table. She did not speak to the resident.</p> <p>After Resident #131 received her meal, LPN #52 indicated from across the room that "someone" was going to have to help Resident #131 eat.</p> <p>CNA #48 approached Resident #71, indicating she was going to "feed" a resident seated near her. She moved</p>			

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F 0242 SS=E Bldg. 00	<p>Resident #71's chair from behind without speaking to the resident in order to get to the table the other resident was seated at.</p> <p>On 4/29/16 at 2:17 p.m., CNA #49 indicated residents were to be spoken to during care.</p> <p>On 4/28/16 at 8:34 a.m., CNA #48 was observed assisting Resident #42 with her breakfast. CNA #48 and CNA # 58 were talking about how Resident #42 "hollers" a lot. Resident #66 was seated at a nearby table with a yogurt in front of him. The Dietary Manager asked CNA #48 if the resident had not wanted his yogurt. CNA #48 indicated Resident #66 had not eaten it.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to promote resident choices for rising times for 2 of 28</p>	F 0242	Resident choice forms to be updated for residents #11, 50 and 175. Care plans for these residents were also updated to	05/29/2016			

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	<p>residents interviewed, for going to bed for 2 of 28 residents interviewed and for not giving more than 2 showers for 1 of 28 residents interviewed concerning choices. (Residents # 11, 50, and 175)</p> <p>Findings include:</p> <p>1. Resident # 11 was interviewed concerning choices on 4/26/16 at 1:15 p.m. She indicated she was the last resident to be prepared for the morning, usually just before lunch. She indicated this was because she was totally dependent, couldn't move her hands, and it took the staff a long time to assist her. She indicated she would prefer to have her shower before breakfast. She indicated she had to go to bed by 10:00 p.m. because there wasn't enough staff on the night shift to get her to bed.</p> <p>CNA # 1 was interviewed on 4/28/16 at 9:00 a.m. She indicated Resident # 11 usually was gotten up " right after breakfast." She indicated that was between 9:30 a.m. and 10 a.m. She indicated, since the resident ate in her room and had to be fed, that was the earliest they had time to get her up.</p> <p>Unit Manager #1 indicated, on 4/28/16 at 9:30 a.m., no residents would get a shower before breakfast because when</p>		<p>include their current wishes regarding choices in their care.All other residents have the potential to be affected by the alleged deficient practice. All resident choice forms to be reviewed for any needed changes and current wishes will be updated on the care plans and C.N.A Kardex.Nursing and Therapy staff to be re-educated regarding the residents right to make choices.DON/Designee to audit the shower list from the previous day to ensure that the resident choices have been documented in the C.N.A point of care documentation and/or any needed follow up.Results of the QA tool will be forwarded to the QA Committee for any additional follow up as needed.</p>		

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	<p>day shift got there it was time for breakfast.</p> <p>The clinical record for Resident # 11 was reviewed on 4/27/16 at 12:45 p.m. Diagnoses included, but were not limited to: multiple sclerosis, contracture of her ankles, depression, neurogenic bladder, and restless leg syndrome.</p> <p>Review of the Minimum Data Set Assessment (MDS), dated 4/8/16, indicated the resident was alert and oriented. It also indicated she was totally dependent on staff for all activities of daily living (adl). It indicated choices were important for her concerning: what clothes to wear, to protect her things, and what time to go to bed. The questionnaire did not ask if it was important what time to get up.</p> <p>Review of the care plan, dated as last reviewed on 4/8/16, indicated the resident had an adl deficit. Interventions included: assist with ADLs - allow her to choose clothing, staff to propel her to destinations, mechanical lift for transfers, total assist with bed mobility, dressing, toileting, a.m. & p.m. care, bathing, brushing teeth, and eating, use of a modified straw, and staff to apply makeup. She also had a problem of anxiety. The interventions for it</p>			

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	<p>included: Anxiety due to totally dependent on staff - allow her to express feelings, encourage to discuss feelings, use support resources, identify strengths & weaknesses, medications as ordered, mental health services, and report side effects.</p> <p>Resident #11 was observed receiving her morning care on 4/28/16 at 11:00 a.m. Two CNAs prepared her for the day with a partial bath, changing her brief, and dressing her. They asked her what she wanted to wear and dressed her in it. The care took about 30 minutes. The activity staff had already applied her makeup for her and she had already eaten breakfast.</p> <p>2. Resident # 50 was interviewed concerning his choices of time to get up in the morning and what time to go to bed on 4/25/16 at 2:20 p.m. He indicated he had no choice for either. He indicated he would sleep later if he had a choice, but staff have to get him up (by Hoyer lift), so he had to get up when they come to get him up. He indicated he would like to go to bed right after supper about 7:00 p.m., but he had to wait until everyone finished supper, usually around 9:00 p.m.</p> <p>Clinical record review for Resident # 50 was begun on 4/28/16 at 1:30 p.m. His</p>			

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	<p>diagnoses included, but were not limited to: depression, constipation, diabetes, chronic obstructive pulmonary disease, and history of stroke.</p> <p>The care plan, dated as last reviewed on 2/10/16, indicated the resident had an adl (activities of daily living) deficit which included his inability to walk, move himself in bed, eat, dress himself, toilet himself, transfer himself, or bathe himself. His care plan indicated he had behaviors of refusing medications and care. His care plan also listed his desire to make choices for his own care. The only choice listed was that he wanted four showers per week.</p> <p>The Minimum Data Set assessment (MDS), dated 2/1/16, indicated it was very important for the resident to choose: his clothes, take care of personal items, choose bedtime. It also indicated the resident was alert and oriented. In addition, the resident was assessed as totally dependent with the help of one to two staff with his limited range of motion on one side.</p> <p>3a. During an interview with Resident #175 on 4/27/16 at 8:46 A.M., she indicated she has never received a shower since arriving at the facility. She also indicated she was offered a shower when she first arrived, but did not feel well and</p>			

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	<p>asked staff if she could take it the next day and never received it. Furthermore, she indicated she took a shower every other day at home and felt that two showers a week at the facility would be enough.</p> <p>During an interview with LPN #17 on 4/28/16 at 8:49 A.M., she indicated if a resident did not want a shower it would be documented as a refusal by the Certified Nursing Assistant (CNA) and/or in a Nurses Note.</p> <p>During an interview with CNA #20 on 4/29/16 at 9:49 A.M., she indicated if a resident refused a shower, she would reapproach at a later time. If the resident still refused, she would try and give them the shower when they preferred it. She also indicated if the resident wanted a shower on a day they were not scheduled to get one, she would try to get it done but it was not always possible.</p> <p>Resident #175's clinical record was reviewed on 4/29/16 at 10:24 A.M. Resident #175 was admitted to the facility on 4/16/16 and current diagnoses included, but were not limited to, gastrointestinal hemorrhage, hospitalization aftercare, muscle weakness, difficulty in walking and fatigue.</p>			

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	<p>Resident #175 had a current, 4/23/16, admission Minimum Data Set assessment which indicated it was very important for her to choose between tub bath, shower, bed bath, or sponge bath.</p> <p>Resident #175 had a current, 4/18/16, care plan need regarding assistance with Activities of Daily Living (ADLs) related to activity intolerance. An intervention for this need was physical assistance with showering. Resident #175 also had a care plan need regarding specific choices. An intervention for this need was that she preferred showers and would receive them twice weekly.</p> <p>Review of a document titled, "Walnut Shower List", dated 4/22/16, and provided by LPN #17 on 4/28/16 at 8:51 A.M., indicated that Resident #175 should receive showers on Tuesdays and Fridays.</p> <p>Review of a document titled, "Showers/Bathing", dated 4/16/16 through 4/29/16 indicated Resident #175 did not receive a shower on any of those dates. It further indicated she received a bed bath on 4/22/16.</p> <p>3b. During an interview with Resident #175 on 4/27/16 at 12:40 P.M., she</p>			

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	<p>indicated [Name of Physical Therapy Assistant] made her go to physical therapy after Resident #175 told the therapist she was not feeling up to it because she had stomach cramps and diarrhea.</p> <p>During an interview with the Physical Therapy Assistant (PTA) on 4/28/16 at 10:11 A.M., she indicated Resident #175 told her she wanted to wait until after breakfast on 4/27/16 to do physical therapy because she wanted to let her food digest. The PTA also indicated she approached Resident #175 in her room at approximately 8:30 A.M. and asked Resident #175 if she was ready for physical therapy. She further indicated that Resident #175 told her she was having diarrhea and did not want to do physical therapy that day. The PTA then indicated that she told Resident #175 that she wanted her to try and Resident #175 did physical therapy on 4/27/16.</p> <p>During an interview with Resident #175 on 4/28/16 at 10:50 A.M., she indicated she had no further episodes of stomach cramps or diarrhea since the previous day. She also indicated she had consented to physical therapy in the morning because she felt better.</p> <p>Review of Resident #175's current,</p>			

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F 0279 SS=D Bldg. 00	<p>4/18/16, care plan indicated a problem of having loose stools.</p> <p>Review of a document titled, "Assisted Living Policy Manual - Resident Rights", dated 3/2014, and provided by the Nurse Consultant on 4/29/16 at 10:30 A.M., included the following: "...J. Residents have the right to the following: ...4) Refuse any treatment or service..."</p> <p>3.1-3(u)(1)</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</p>			

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	<p>§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 observation, record review and interview, the facility failed to develop a care plan for use of an immobilizer for 1 of 23 residents reviewed for comprehensive care plans (Resident #156).</p> <p>Findings include:</p> <p>During an observation of Resident #156 on 4/27/16 at 1:42 P.M., she was sitting on the edge of her bed. She had a removable knee immobilizer in place to her left knee.</p> <p>During an interview with Resident #156 on 4/27/16 at 1:42 P.M., she indicated she kept the immobilizer in place to her left knee at all times except when she showers and puts pants on.</p> <p>During an interview with Resident #156 on 4/28/16 at 10:30 A.M., she indicated she was in the facility when she broke her left knee cap. She also indicated she had broken her right knee before she was admitted to the facility.</p> <p>During an interview with RN #21 on 4/28/16 at 10:35 A.M., she verified that Resident #156 had fractured both knees.</p>	F 0279	Care plan has been developed for resident #156 addressing the immobilizer. All residents have the potential to be affected by the alleged deficient practice. Care plans will be reviewed for any residents residing in the facility utilizing a brace/splint/immobilizer to ensure a care plan has been developed. Unit Managers will be re-educated regarding monitorin for changes and updating the plan of care accordingly. Admission orders, daily Physican's orders and the 24 hour report will be reviewed daily for any needed updates in the plan of care. Daily auditing checklists to be completed each day and forwarded to the DON for review. Results of the daily audits will be forwarded to the QA Committee for review.	05/29/2016

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	<p>During an interview with LPN #22 on 4/28/16 at 10:38 A.M., he indicated that Resident #156 fractured her left knee on 3/19/16 in the facility.</p> <p>Resident #156's clinical record was reviewed on 4/27/16 at 11:17 A.M. Resident #156's admission diagnosis included, but was not limited to, right patellar fracture. Resident #156's current diagnosis included, but was not limited to, left patellar fracture.</p> <p>Resident #156 had an admission Minimum Data Set (MDS) assessment, dated 12/14/15 which indicated she needed extensive assistance with mobility and used a walker and a wheelchair.</p> <p>Resident #156 had a 12/7/15 admission care plan. There was no documentation regarding an immobilizer.</p> <p>Resident #156 had a 1/12/16 care plan need regarding the need to walk to keep endurance and balance. An intervention was to wear immobilizer at all times which was initiated on 4/14/16.</p> <p>Review of Resident #156's "Medication Review Report" for the month of December 2015 included the following: "...Immobilizer to right knee in place at</p>			

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	<p>all times..."</p> <p>Review of a "Discharge Summary" dated 11/27/15 and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., included the following: "...DISCHARGE DIAGNOSIS: Inferior patellar fracture and right knee effusion... recommended conservative management and to place a brace on the right knee..."</p> <p>Review of a document titled, "Initial Pressure Ulcer Report", dated 12/16/15, and provided by the Director of Nursing (DON) on 4/29/16 at 10:08 A.M., included the following: "...Immobilizer causing pressure. Area covered with foam dressing. [sic] to relieve rubbing..."</p> <p>Review of a document titled, "Dietary-nutritional risk assessment", dated 12/16/15, and provided by the DON on 4/29/16 at 10:08 A.M., included the following: "...s/p (status post) patellar fracture and is to wear right knee immobilizer..."</p> <p>Review of a document titled, "Policy for Prevention of Pressure Ulcers", undated, and provided by the Nurse Consultant on 4/29/16 at 10:30 A.M., included the following: "...Prevention measures shall include, but not be limited to: Assessment of risk on admission to the</p>			

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F 0282 SS=D Bldg. 00	<p>facility and at regularly scheduled intervals... Nursing care shall include: ...Institution of measures to reduce the effects of pressure, friction, and shear.</p> <p>3.1-35(a)</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.</p> <p>Based on observation, interview and record review, the facility failed to follow physician orders related to notification of weight gain, administration of an antibiotic medication and an increase of an antipsychotic medication for 3 of 23 residents reviewed for following physician orders. (Resident #154, #174 and #31)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #154 was reviewed on 4/27/16 at 1:06 p.m. Diagnoses included, but were not limited to, chronic systolic congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, primary</p>	F 0282	Nurse Practitioner has been notified of the previous weight loss and IV antibiotic delay in treatment. Antipsychotic for resident #31 has been increased as previously ordered. All residents have the potential to be affected by the alleged deficient practice. A review of the progress notes for residents receiving psychiatric services will be reviewed for the last 30 days. The facility has changed psychiatric service providers that will be inputting orders directly into PCC. QAPI/Physicians/Nurse Practitioners will be in-serviced to communicate all new orders to the Licensed Nurse.QAPI Nurse to review all progress notes in PCC 5 days a week.Review to be forwarded to the QA Committee	05/29/2016

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	<p>pulmonary hypertension, edema, pleural effusion and injury of kidney.</p> <p>A review of Resident #154's current physician orders indicated the following:</p> <p>"...Weekly weight - Notify Physician of a weight gain 3 lbs. [pounds] or greater. every [Every] day shift every Thur [Thursday] related to HEART FAILURE, UNSPECIFIED...order date...01/04/2016...."</p> <p>A review of Resident #154's "Weight Summary", dated 1/7/16 to 4/21/16, indicated the following:</p> <p>On 3/3/16 Resident #154's weight was 148.6 pounds and on 3/22/16 it was 159.4 pounds, which indicated a 10.8 pound weight gain in 19 days.</p> <p>A review of Resident #154's "Progress Notes" indicated the following:</p> <p>"...3/24/2016 [at] 10:08 [a.m.] Type: Nurses Note...notified family of weight gain...</p> <p>...3/22/2016 [at] 14:47 [2:47 p.m.] Type: Dietary PN [Progress Note]...W/C [wheelchair] wt. [weight] obtained today at 159.4 # [pounds]; with significant gain noted. Will monitor.</p>		upon completion for review.		

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	<p>...4/20/2016 [at] 11:43 [a.m.] Type: Nurses note...NP [Nurse Practitioner] made aware of resident having a 16.8 pound weight gain over the past 120 days. No new orders at this time."</p> <p>No further information was provided at time of exit on 4/29/16.</p> <p>2. Resident #174's clinical record was reviewed on 4/26/16 at 10:52 A.M. Resident #174's current diagnosis included, but was not limited to, streptococcal infection.</p> <p>Review of a document titled, "[Name of Hospital] Discharge Summary", dated 4/16/16, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., included the following: "...He was advised to be continued on Rocephin [an antibiotic] 1 g [gram] IV [intravenously] daily for 7 days and Vibramycin [an antibiotic] 100 mg [milligrams] IV twice a day for 7 days while in the nursing home undergoing therapy..."</p> <p>Review of Resident #174's "Medication Administration Record" for April 2016, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., indicated Resident #174 did not receive Vibramycin for two doses on 4/17/16, two doses on 4/18/16, one dose on</p>			

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	<p>4/19/16, and one dose on 4/25/16.</p> <p>Review of "Progress Notes", dated from 4/17/16 through 4/25/16, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., included the following:</p> <p>"...4/17/16 10:00 [A.M.]... upon reviewing discharge note from hospital, [Name of Physician] had suggested continuing Vibramycin and Rocephin iv [sic] for 7 days for strep sanguinus [sic] found on blood culture. no orders were written to continue these meds, no iv [sic] line in place. Call placed to NP [Nurse Practitioner]... order recd [received] to continue..."</p> <p>"...4/17/16 12:00 [noon]... Will start IV antibiotics as soon as midline placed..."</p> <p>"...4/18/16 10:46 [A.M.]... Called [Name of Pharmacy] regarding IV supplies since have not received at this time. Spoke to pharmacist [Name of Pharmacist] and they do not have it in their [sic] IV department, they are working on getting this and all supplies to us..."</p> <p>Review of a facility policy titled, "Administrative Physician's Orders", dated 1/2012, and provided by the Director of Nursing on 4/29/16 at 10:59 A.M., included the following: "...</p>			

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	<p>Purpose: To provide general guidelines when receiving, transcribing, notification, and care planning physician's orders...Check for any orders that require verification. The orders will be verified by the nurse and the instructions for the order will be completed..."</p> <p>During an interview with LPN #19 on 4/28/16 at 11:11 A.M., she indicated if an antibiotic was not available she would contact the physician or NP to see how they would proceed.</p> <p>During an interview with a facility NP on 4/28/16 at 11:29 A.M., he indicated a physician or NP is on-call 24/7 and should be notified if a medication, especially an IV antibiotic, was unavailable from pharmacy. He further indicated the physician or NP would determine if it would be ok to wait for the antibiotic to arrive or if another antibiotic would be used if the gap in treatment was too long. Furthermore, he would expect a facility nurse to call as soon as they knew an antibiotic was unavailable.</p> <p>3. Resident #31's clinical record was reviewed on 4/27/16 at 2:35 P.M. Resident #31's current diagnoses included, but were not limited to, schizoaffective disorder, dementia and major depressive disorder.</p>			

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	<p>Resident #31 had a current, 2/2/16, significant change, Minimum Data Set (MDS) assessment which indicated she received antipsychotic medications and exhibited no psychotic behaviors.</p> <p>Resident #31 had a 2/9/16 care plan problem regarding depression and a history of behavioral problems that included ineffective coping and verbal/physical aggression.</p> <p>A document titled, "Order Summary Report", dated 4/29/16, and provided by LPN #17 on 4/29/16 at 3:15 P.M., indicated Resident #31 received Seroquel (an antipsychotic) 25 milligrams (mg) daily.</p> <p>A Consultation Report from the facility's pharmacy provider, dated 11/25/15, and provided by LPN #17 on 4/29/16 at 3:15 P.M., indicated a gradual dose reduction (GDR) of Seroquel should be attempted unless contraindicated. It also indicated that a facility psychiatrist accepted the recommendation on 12/2/15 and decreased the dose of Seroquel to 12.5 mg daily.</p> <p>A Medication Administration Record for the month of December 2015, provided by LPN #17 on 4/29/16 at 3:15 P.M.,</p>			

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F 0312 SS=D Bldg. 00	<p>indicated Resident #31 received Seroquel 12.5 mg daily from 12/3/15 - 12/31/15.</p> <p>A Progress Note, dated 12/18/15, provided by LPN #17 on 4/29/16 at 3:15 P.M., indicated the facility psychiatrist increased the dose of Seroquel to 25 mg daily for "more agitation and mood swing [sic]". It also indicated the dose was not increased until 1/7/16.</p> <p>During an interview with the Unit Manager of the 300 Hall, LPN #17, on 4/29/16 at 3:12 P.M., she indicated the facility psychiatrist possibly forgot to leave a copy of his progress note or it somehow got misplaced and the facility did not receive the progress note until it was faxed on 1/6/16.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview, observation and record review, the facility failed to ensure personal hygiene related to shaving of facial hair for 1 of 35 residents observed</p>	F 0312	Facial hair for resident #16 has been removed. All residents have the potential to be affected by the alleged deficient practice. Residing residents will be	05/29/2016			

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	<p>for grooming needs. (Resident #16)</p> <p>Findings include:</p> <p>The clinical record of Resident #16 was reviewed on 4/26/16 at 3:01 p.m. Diagnoses for the resident included, but were not limited to; Alzheimer's disease, hypothyroidism, cognitive communication deficit, diabetes mellitus type II and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>During a family interview on 4/26/15 at 10:55 a.m., the family member of Resident #16 indicated it frustrated Resident #16's son that the facility did not keep his mother's facial hair shaved. The family member further indicated if Resident #16 was cognitively aware of the facial hair it would bother her.</p> <p>During an observation on 4/27/16 at 4:18 p.m., Resident #16 was observed laying in bed with white facial hair on and under her chin.</p> <p>During an observation on 4/28/16 at 9:25 a.m., Resident #16 was observed in her broda chair in her room with white facial hair on and under her chin.</p> <p>During an observation on 4/28/16 at</p>		<p>reviewed to ensure proper grooming and personal hygiene. Personal hygiene is evident. Dignity form to be utilized 5 days a week to ensure the residents personal hygiene is evident. The resident dignity tool will be completed 5 times a week for 12 weeks and one time monthly ongoing to ensure compliance. Results of the dignity tool audits to be forwarded to the QA Committee for review.</p>	

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	<p>11:37 a.m., Resident #16 was observed in her broda chair with white facial hair on and under her chin.</p> <p>During an interview with Unit Manager #48 and the Director of Nursing on 4/29/16 at 9:36 a.m., Unit Manager #48 indicated grooming was included when a resident received a shower and included the removal of facial hair by shaving. Unit Manager #48 further indicated he had just noticed Resident #16's facial hair today and it would be taken care of.</p> <p>During a review of the current "...Shower List", provided by the Medical Records Coordinator on 4/29/16 at 9:32 a.m., the list indicated Resident #16 would be showered on Tuesdays and Fridays during second shift.</p> <p>During a review of the "Showers/Bathing" report for Resident #16, dated 4/23/16 to 4/29/16, the report indicated Resident #16 received a shower and shampoo on 4/26/16.</p> <p>Review of a policy, dated 6/2013, and titled "Personal Hygiene" was provided by the Director of Nursing on 4/29/16 at 10:59 a.m. It indicated the following:</p> <p>"...Purpose: To ensure residents receive necessary care and assistance for personal</p>			

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F 0353 SS=E Bldg. 00	<p>hygiene tasks.</p> <p>...Policy:</p> <p>1. Personal hygiene will be performed 2 times daily in the morning and before bed...</p> <p>...4. Personal hygiene may include, but is not limited to:</p> <p>...g. Shaving</p> <p>No further information was provided at exit on 4/29/16.</p> <p>3.1-38(a)(3)(D)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a</p>						

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	<p>licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to staff at a level in order to provide care to residents on the 200 hall. This practice had the potential to affect the 57 residents residing on the 200 hall of 98 total residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview, on 4/26/16 at 1:24 p.m., Resident #11 indicated she was not able to get up in the morning according to her preference. She further indicated she did not get to go to choose what time she went to bed.</p> <p>During an interview, on 4/25/16 at 2:18 p.m., Resident #50 indicated he would like to be able to stay in bed until around 7:30 a.m. and would like to go to bed right after supper. He indicated his bedtime depended on who was working, and he sometimes did not get to bed until after 9:00 p.m.</p> <p>During an interview, on 4/27/16 at 8:46 a.m., Resident #175 indicated she had not received a shower in the 13 days since her admission.</p> <p>The Hickory Lane & Redbud Court 3rd</p>	F 0353	<p>Residents #11, 50 and 175 have been reviewed to ensure their care needs have been met in accordance with their care plans. All residents have the potential to be affected by the alleged deficient practice. DON/Administrator have reviewed the care needs in the facility to ensure sufficient staff is available to meet the resident's needs. Staffing levels have been modified based on care needs. Abaqis interviews will be conducted with residents and families to validate sufficient staffing, 5 interviews will be conducted 3 times a week for 6 weeks to ensure compliance. Randomly every 4 months thereafter ongoing. Results of interviews to the QA Committe for any additional follow up as needed.</p>	05/29/2016			

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	<p>Shift Get Up List was provided by Unit Manager # 1 on 4/27/16 at 1:00 p.m. The Unit Manager indicated this list told the CNAs who should be awakened and dressed before the day shift arrived at 6:00 a.m. He indicated he had recently revised the list, but no one was to be awakened before 5 a.m. The list indicated 3 of 5 residents on Redbud Court and 1 of 5 residents on Hickory Lane were to have been dressed and left in bed. When asked about this, he indicated other residents complained if they were awakened this early, so he had chosen residents who wouldn't complain. He also indicated resident choices were not indicated anywhere but on the care plan.</p> <p>During an interview, on 4/28/16 at 10:17 a.m., CNA #38 indicated staff was usually able to get Resident #11 out of bed by 9:30 or 10 in the morning, but sometimes it was later.</p> <p>During an interview with the Staffing Coordinator and the DON on 4/29/16 at 2:18 p.m., the Staffing Coordinator indicated ideal staffing for the current facility census of 98 residents would be 340 staff hours per day. This included both nurses and CNAs. A nurse on each hall was ideal with a minimum of 4 nurses for both days and evening shifts</p>			

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	<p>and 3 on night shift. The CNA staffing hours were split up after the nurses were staffed, with the maximum being 3 CNAs on each hall, with the exception of the Walnut unit (rehab unit), which was 2 CNAs. She indicated the facility generally had 2 CNAs on each hall, but are "upping the game" at times and staffing 3 CNAs on the Redbud and Hickory units [200 hall]. When questioned about how often 3 CNAs are on each unit on the 200 hall, the DON indicated there were usually 2 CNAs on each unit with one CNA or QMA "floating" to help each unit. The Staffing Coordinator indicated she would, at times, pull the day shift QMA, who is scheduled Monday through Friday to help the nurses, and have them help the CNAs. When questioned about who would then do the QMA's work, the Staffing Coordinator indicated the nurses do the QMA's assignment. She indicated she was not aware of the resident's needs not being met with the current staffing procedures.</p> <p>During an interview, on 4/29/16 at 2:35 p.m., CNA #58 indicated evening shift was usually, if not always, staffed with 2 CNAs on both of the 200 hall units. She indicated this practice made it difficult to get showers done at times and they would have to try to get them done the next day,</p>			

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F 0425 SS=D Bldg. 00	<p>but it wasn't always possible.</p> <p>During an interview, on 4/29/16 at 2:45 p.m., CNA #57 indicated the 200 hall was staffed with 2 CNAs on each unit in the evenings. She indicated it was difficult to get showers done and a lot of the time they could only "wash up" residents really well. She indicated it required 2 staff members to transfer a resident with a mechanical lift.</p> <p>Unit Manager #44 indicated on 4/29/16 at 3 p.m., there were 10 of 28 residents on the Redbud unit requiring the use of a mechanical lift for transfers on the 200 hall and 7 of 29 residents on the Hickory unit requiring the use of a mechanical lift for transfers of the 200 hall. The Chestnut unit had 2 of 26 residents requiring a mechanical lift for transfers and the Walnut unit had 2 of 17 residents requiring a mechanical lift for transfers.</p> <p>3.1-17(a)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law</p>						

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	<p>permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure an IV antibiotic was available from the pharmacy for 1 of 5 residents reviewed for unnecessary medications (Resident #174).</p> <p>Findings include:</p> <p>Resident #174's clinical record was reviewed on 4/26/16 at 10:52 A.M. Resident #174's current diagnosis included, but was not limited to, streptococcal infection.</p> <p>Review of a document titled, "[Name of Hospital] Discharge Summary", dated 4/16/16, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., included the following: "...He was advised to be continued on Rocephin [an antibiotic] 1 g [gram] IV [intravenously] daily for 7 days and Vibramycin [an</p>	F 0425	Nurse Practitioner notified of delay in antibiotic therapy treatment for resident #174. Residents residing in the facility have the potential to be affected by the alleged deficient practice. A review to be conducted for all residents that have received antibiotic therapy in the last 90 days to ensure no other residents have been affected by the alleged deficient practice. All Physician admission orders as well as the daily orders will be reviewed 5 times weekly. Results of the reviews will be forwarded to the QA Committee for review.	05/29/2016			

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	<p>antibiotic] 100 mg [milligrams] IV twice a day for 7 days while in the nursing home undergoing therapy..."</p> <p>Review of Resident #174's "Medication Administration Record" for April 2016, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., indicated Resident #174 did not receive Vibramycin for two doses on 4/17/16, two doses on 4/18/16, one dose on 4/19/16, and one dose on 4/25/16.</p> <p>Review of "Progress Notes", dated from 4/17/16 through 4/25/16, and provided by the Nurse Consultant on 4/28/16 at 11:42 A.M., included the following:</p> <p>"...4/17/16 10:00 [A.M.]... upon reviewing discharge note from hospital, [Name of Physician] had suggested continuing Vibramycin and Rocephin iv [sic] for 7 days for strep sanguinus [sic] found on blood culture. no orders were written to continue these meds, no iv [sic] line in place. Call placed to NP [Nurse Practitioner]... order recd [received] to continue..."</p> <p>"...4/17/16 12:00 [noon]... Will start IV antibiotics as soon as midline placed..."</p> <p>"...4/18/16 10:46 [A.M.]... Called [Name of Pharmacy] regarding IV supplies since</p>			

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F 0431 SS=F Bldg. 00	<p>have not received at this time. Spoke to pharmacist [Name of Pharmacist] and they do not have it in their [sic] IV department, they are working on getting this and all supplies to us..."</p> <p>During an interview with LPN #19 on 4/28/16 at 11:11 A.M., she indicated if an antibiotic was not available she would contact the physician or NP to see how they would proceed.</p> <p>During an interview with a facility NP on 4/28/16 at 11:29 A.M., he indicated a physician or NP is on-call 24/7 and should be notified if a medication, especially an IV antibiotic, was unavailable from pharmacy. He further indicated the physician or NP would determine if it would be ok to wait for the antibiotic to arrive or if another antibiotic would be used if the gap in treatment was too long. Furthermore, he would expect a facility nurse to call as soon as they knew an antibiotic was unavailable.</p> <p>3.1-25(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who</p>						

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	<p>establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were stored in a hygienic and orderly manner for 1 of 2 medications rooms (Hickory/Redbud), 4 of 4 medication carts, and 4 of 4 treatment carts. This practice had the potential to affect 26 of 26 residents on</p>	F 0431	The medication carts, treatment carts and medication rooms will be corrected to ensure compliance. All residents have the potential to be affected by the alleged deficient practice. The medication carts, treatment carts and medication rooms will be audited one time a week for 12 weeks by the Unit Managers	05/29/2016

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	<p>the Chestnut unit, 17 of 17 residents on the Walnut unit, 29 of 29 residents on the Hickory unit, and 28 of 28 residents on the Redbud unit.</p> <p>Findings include:</p> <p>A medication storage observation, beginning on 4/29/16 at 9:15 a.m., and accompanied by Unit Manager (UM) # 45, of the Hickory and Redbud Unit medication room indicated the following:</p> <p>Two wall cabinets, labeled as containing liquid and as-needed medications, the following was observed with no resident identifiers:</p> <p>One bottle of Colace 100 mg capsules.</p> <p>Three bottles of B-12 1000 mg tablets, one with "ED" marked on the lid and two with no markings.</p> <p>Three bottles of D-3 2000 IU (international units) capsules, one with "ED" marked on the lid, and two with no markings.</p> <p>One bottle of Fish Oil 1000 mcg capsules.</p> <p>One bottle of Miralax (a laxative).</p>		<p>ensuring substantial compliance with medication storage and appropriate labeling. Audits will continue quarterly ongoing. Nursing staff to be re-educated regarding the appropriate storage of medications and appropriate labeling. Results of the medication room, treatment carts and medication carts will be forwarded to the QA Committee for review.</p>		

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	<p>One bottle of Cranberry 25,200 mg tablets.</p> <p>A drawer near the door, contained, but was not limited to, batteries, a screwdriver, salt and pepper packets, an alert bracelet, lubricating jelly packets, syringes, and medical tape, a bottle of Tussin DM cough syrup with what UM #45 estimated as 3 ounces gone from it, and a 60 gram tube of Desonide cream (topical steroid) with a partial pharmacy label on it.</p> <p>During an observation of the Chestnut medication cart, the following was observed:</p> <p>In the third drawer of the cart, one bottle of Vitamin D-3 400 IU and one bottle of Vitamin D-3 1000 IU with "RR" marked on the lid and no other resident identifiers.</p> <p>During an observation of the Chestnut Unit treatment cart, the following was observed:</p> <p>In the top drawer of the cart, four 3 ounce tubes of moisturizing body cream and three 3 ounce tubes of antifungal cream were observed sitting in a puddle of a clear, filmy substance. In the same drawer, an open 2 x 2 inch Aquacel AG</p>			

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	<p>dressings and open paper sack of cotton applicators were observed with the applicators spilling out into the drawer.</p> <p>In the third drawer of the cart, an open package of wound closure strips were observed.</p> <p>The fourth drawer, contained various wound dressings and bandages UM #45 identified as being for community use, with the following also observed:</p> <p>An open package with a portion of a 4 x 4 inch hydrocolloid dressing.</p> <p>An open package with a portion of a 4 x 4 inch Xeroform dressing.</p> <p>A bottle of Hibiclens (antiseptic skin cleanser), a 1-pound jar of Eucerin cream, a 1-pound jar of petroleum jelly, and three 1-pound jars of Aquaphor skin cream, belonging to different residents. The containers were not separated in any manner.</p> <p>An observation of the Walnut unit medication cart indicated the following:</p> <p>One bottle of Bayer 81 mg tablets and one bottle of Tylenol 500 mg tablets for a resident that had discharged from the facility on 4/26/16.</p>			

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	<p>UM #45 indicated the medications should have been destroyed or sent home with the resident's family at the time of discharge from the facility.</p> <p>In the second drawers of the cart, 4 loose pills were observed.</p> <p>An observation of the Walnut unit treatment cart indicated the following:</p> <p>In the third drawer, also containing various wound dressings and bandages UM #45 identified as for community use, was the following:</p> <p>A 7 ounce bottle of odor spray.</p> <p>A 12 ounce bottle of wound cleanser marked "4/2" with no resident identifiers.</p> <p>A 12 ounce bottle of wound cleanser marked "4/11" with no resident identifiers.</p> <p>A container of bleach wipes and container of sanitizing hand wipes, each containing #160 wipes in similar packaging.</p> <p>A 14 ounce jar of Aquaphor covered in a clear film, a 1 pound jar of petroleum jelly, a bottle of ammonium lactate lotion</p>			

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	<p>(moisturizer),all belonging to different residents. An open bulk package of 4 x 4 inch gauze dressings and a open package containing a partial foam dressing. The items were not separated in any manner.</p> <p>An observation of the Hickory and Redbud Unit medication and treatment carts, beginning on 4/29/16 at 10:50 a.m., and accompanied by Unit Manager #47, indicated the following:</p> <p>In the Hickory unit medication cart, the following was observed:</p> <p>In the top drawer, a glucometer sat uncovered in a box containing packages of alcohol swabs. Three individually wrapped oatmeal cookies sat next to the empty glucometer case, next to the insulin syringes.</p> <p>One loose pill was observed in the second drawer of the cart.</p> <p>In the third drawer, one bottle of Vitamin D-3 2000 IU marked with a physician's name and no resident identifiers. One loose Warfarin 2.5 mg tablet in foil packaging and 5 additional loose pills were also observed in the drawer.</p> <p>In the fourth drawer, an open bottle of Humalog insulin was without an open</p>			

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	<p>date.</p> <p>UM #47 indicated the insulin should have been marked with an open date. A bottle of Vitamin D-3 1000 IU was marked with (resident first name) on the lid and a physicians name on the side. There were no other resident identifiers on the bottle.</p> <p>During an observation of the Hickory unit treatment cart, the following was observed:</p> <p>Two bottles of Nystop 100,000 units powder (anti-fungal), Fluocinonide 0.05% (topical steroid), Eucerin cream, dandruff shampoo and skin lotions, all belonging to different residents, stacked on top of each other, and not separated in any manner.</p> <p>In the fourth drawer, two open packages of calcium alginate wound packing marked "4/20/16" and "4/22/16 gluteal fold" were observed.</p> <p>In the fifth drawer, containing various wound dressings and bandages, identified by UM #47 as for community use, an open bulk package of 4 x 4 inch gauze pads was observed next to two 1 pound jars of Aquaphor, belonging to different residents. The jars were not separated in</p>			

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	<p>any manner.</p> <p>In the sixth drawer, an 8 ounce bottle of peri cleanser was stored next to an 8 ounce bottle of odor eliminator. A 250 milliliter bottle of Dakin's solution (bleach-based wound cleanser) belonging to a resident was stored next to an 8 ounce bottle of wound cleanser belonging to another resident. The containers were not separated in any manner.</p> <p>An observation of the Redbud medication cart indicated 4 loose pills in the third drawer of the cart and 5 loose pills in the fourth drawer of the cart.</p> <p>An observation of the Redbud treatment cart indicated the following: Two open wound closure dressings were observed in the top drawer of the cart. In the second drawer of the cart, an open partial calcium alginate 4 x 4 inch wound dressing and an open partial hydrocolloid 4 x 4 inch wound dressing were observed. An open roll of gauze with no resident identifier was observed in the fourth drawer of the cart.</p> <p>In the fifth drawer of the cart, a 1 pound jar of petroleum jelly, a 1 pound jar of Ceravue (moisturizer), and two 1 pound jars of Aquaphor, all belonging to different residents were stored next to a</p>			

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	<p>stack of four tracheostomy care trays. The containers were not separated in any manner.</p> <p>UM #45 and UM #47 indicated at the time of the Hickory/Redbud medication room observation that all medications were to be labeled with resident identifiers and directions.</p> <p>Review of a policy titled, "Guidelines for the Storing of Medications", dated April 29, 2016 and provided by the Nurse Consultant on 4/29/16 at 9:50 a.m., indicated the following:</p> <p>"...3. All discontinued, outdated, or deteriorated medications will be destroyed or sent back to the pharmacy...</p> <p>...5. Antiseptics, disinfectants, and germicides used in resident care must have legible, distinctive labels that identify the contents and directions for use. These are to be stored separately from the regular medications...</p> <p>...7. Medications are stored in an orderly manner in cabinets, drawers, or carts. These compartments are of sufficient size to prevent crowding...8...Medications must be stored separately from food..."</p> <p>3.1-25(j)</p>			

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F 0441 SS=E Bldg. 00	<p>3.1-25(k) 3.1-25(l) 3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p>			

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	<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. Based on observation, interview, and record review, the facility failed to assure infection control procedures were used during pericare, gastric tube care, and oral care using 6 of 8 direct care staff, during 3 of 3 staff doing laundry pass, during 3 of 4 staff doing medication pass, and 1 of 1 housekeeping staff observations as well as medication storage. (CNA #1, CNA #2, LPN #45)</p> <p>Findings include:</p> <p>Direct care Observations:</p> <p>1. Resident # 11 was observed on 4/28/16 from 11 a.m. to 11:30 a.m. with CNA # 1 and CNA 32 providing care. The resident was positioned on her back and perineal care was performed. Both CNAs washed their hands and donned gloves. CNA # 2 proceeded to uncover the resident. She then removed the soiled brief from the resident's abdomen. She folded the brief down into the peri-area and washed and dried the peri-area with a soaped washcloth and a non-soaped</p>	F 0441	The facility is unable to correct the alleged deficient practice for resident #11, 124 and 173. All residents have the potential to be affected by the alleged deficient practice. Nursing and laundry staff to be re-educated on infection control procedures. Nursing staff responsible for medication pass will be re-educated on the appropriate dispensing of all forms of medications. Unit Managers to conduct weekly medication observations for 12 weeks to ensure appropriate compliance with medication pass and then quarterly ongoing. Housekeeping Supervisor to observe weekly infection control procedures by the laundry personnel weekly for 12 weeks and then quarterly ongoing to ensure appropriate compliance with infection control procedures. Audits to be forwarded to the QA Committee for review.	05/29/2016			

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	<p>washcloth. She did not wash the labia. The resident then was turned toward CNA # 1. CNA # 2 removed the brief from under the resident and layed it to one side on the bed. CNA # 2 then washed the resident's buttocks and anus starting with washing the rectal area first, then the buttocks. She rinsed and dried the area, starting with the rectal area first, then the buttocks. The two CNAs then positioned a clean brief under the resident. The resident requested the CNAs apply protective cream to the peri-area prior to finishing with the brief. CNA #2, while still wearing the same gloves, took the tube of cream from the resident's dresser. She then squeezed the cream into her gloved hand. She applied the cream to the anal area first, then to the resident's buttocks. The resident was then rolled over onto her back. CNA # 2 squeezed more cream into her gloved hand and applied the cream to the front of the peri-area. The 2 CNAs then fastened the brief in place. Then they both removed their gloves and washed their hands. Clean washcloths were used for the rest of the partial bath the resident received.</p> <p>The procedure for doing "Perineal Care" was provided by the Consultant Nurse on 4/29/16 at 11 a.m. The procedure read as follows:</p>			

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	<p>"...9. Fill wash basin with warm water and have the resident check the temperature.</p> <p>10. Put on gloves.</p> <p>11. Wet and soap the folded washcloth...</p> <p>14. Wipe from the front to the back and from the center of the perineum (sic) to the thighs. Change wash cloth as needed. Place soiled linen in plastic bag. Do not let any linen touch the floor.</p> <p>For Female: A. Separate the labia. Wash the urethral area first. B. Wash between and outside the labia in downward strokes. Alternate from side to side and move outward to the thighs. Use a different part of the wash cloth for each stroke...</p> <p>15. Change the water in the basin and use a clean wash cloth. Rinse the area thoroughly in the same direction as when washing.</p> <p>16. Pat the area dry in the same direction as washing.</p> <p>17. Assist the resident in turning onto their side away from you...</p> <p>18. Wet and soap a new wash cloth.</p> <p>19. Clean the anal area from the front to the back. Rinse and pat dry in the same fashion for the front.</p> <p>20. Assist the resident in turning onto their back...</p> <p>21. Remove gloves and perform hand hygiene...."</p> <p>2. During a resident interview on 4/25/16</p>			

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	<p>at 2:45 p.m., LPN #45 was observed to use her index finger to pull a brown pill out of a clear, plastic 30 milliliter cup for Resident #124.</p> <p>During an interview with LPN #124 on 4/29/16 at 2:14 p.m., she indicated she did not remember touching the medication with her finger. She further indicated the practice would be to not touch the medication with her bare finger.</p> <p>3. During a laundry pass observation on the Chestnut Unit, beginning on 4/27/16 at 7:51 a.m., an uncovered laundry cart was in the hallway outside of room 325, with a medication cart and three residents alongside the cart. Laundry Aide #50 wiped her nose with her left hand and picked up a pile of clothing from the cart and entered room 324, carrying the clothing against her chest. Laundry Aide #50 returned to the cart, removed hangers of clothing, and carried them to room 328. She returned to the cart, removed a small basket containing clothing, and carried it to room 329. The cart remained uncovered. Laundry Aide #50 returned to the cart and removed a hanger with a pair of pants, entered room 332, and then returned with the pants and hung them on the outside of the laundry cart. She removed more hangers from the uncovered cart and swung them around to</p>			

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	<p>her back, laying them against her back and hooking the hanger with the fingers of her right hand. She carried the clothing to room 332. She again returned to the cart, removed a stack of shirts and held them against her while she entered room 333. She asked the resident in the room if the shirts were theirs, while she looked through the dresser drawers with her right hand, still holding the shirts against her with her left hand. She returned the shirts to the cart. The Housekeeping Supervisor approached the laundry cart, removed the hanging pants from the outside of the cart and placed them inside the cart, and pulled the cover down over the laundry cart.</p> <p>On 4/27/16 at 8:02 a.m., Laundry Aide #50 indicated she didn't usually cover the cart when she passed laundry and that she had "learned something new today" when the Housekeeping Supervisor had approached her.</p> <p>During a medication administration observation, beginning on 4/28/16 at 8:30 a.m., RN #41 prepared oral medications and insulin for Resident #173. During the preparation of the medications, RN #41 touched the sharps container on the medication cart. She did not perform hand hygiene after touching the container. She placed the medications,</p>			

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	<p>insulin syringe, and vial of eye drops onto a clipboard that had been sitting on top of the medication cart. When she entered the resident's room, she place the clipboard on the resident's bedside table, next to his breakfast tray. After administering the oral medications and insulin, RN #41 donned gloves and administered eye drops to Resident #173. She did not perform hand hygiene prior to administering the eye drops.</p> <p>During an observation of medication administration via gastric tube, beginning on 4/28/16 at 9:13 a.m., RN #41 carried Resident #55's medications and a cup of mouthwash to his room on a clipboard used to carry medications to another resident's room. The clipboard had not been sanitized. She placed the clipboard onto the resident's bedside table. RN #41 donned a glove to her right hand and then turned on the right sink faucet. She then donned a glove to her left hand and used both hands to adjust the sink faucets. She then filled two cups with water to use for the gastric tube flush. RN #41 administered Resident #41's medications per his gastric tube, while wearing the same gloves and retrieving the medication cups from the same clipboard used to carry Resident #173's medications. RN #41 donned new gloves after administering the medications and</p>			

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	<p>flushes and indicated to the resident she needed to perform his oral care. She then opened the drawers on two different dressers, indicating she was looking for a toothette. She then removed the gloves and went to the medication cart and retrieved a toothette from the top drawer. She returned to the resident's room and applied gloves and cleaned the resident's mouth using the mouthwash on the clipboard.</p> <p>During an interview following the medication observation, RN #41 indicated she should not have touched the faucet with the gloves and she should have performed hand hygiene prior to administering the eye drops. She further indicated she should have performed hand hygiene after touching the medication cart.</p> <p>During a medication administration observation, beginning on 4/28/16 at 3:30 p.m., RN #43 administered nasal spray to Resident #103. Following the nasal spray administration, RN #43 did not perform hand hygiene, and while not wearing gloves, she administered eye drops to Resident #103 with her left hand while pulling down the lower lid of his eye with her right hand. She then retrieved a tissue from the night stand and wiped the resident's left eye, then his right eye, and</p>			

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	<p>then his left eye again with the same area of the tissue. She indicated to the resident his eyes were "getting red again", while she wiped a small amount of yellow drainage from his eye.</p> <p>On 4/28/16 at 4:19 p.m., RN #41 indicated she should wear gloves when administering eye drops.</p> <p>On 4/29/16 at 7:55 a.m., a laundry cart was observed in the hallway outside of room 334. A large fan was blowing into the laundry cart, lifting the cover, and exposing the laundry inside the cart. Laundry Aide #42 removed a dress on a hanger from the cart and bent down to the shelf on the bottom of the cart, dragging the dress on the floor. Laundry Aide #42 entered room 333 with the dress.</p> <p>On 4/29/16 at 8:01 am., Laundry Aide #42 indicated she was aware clothing was not to touch the floor. She further indicated the laundry cart was to remain covered and she probably shouldn't have had it in front of the fan.</p> <p>On 4/29/16 at 2:03 p.m., the Director of Nursing and Nurse Consultant indicated infection control practices were to be followed during medication pass.</p> <p>On 4/29/16 at 2:33 p.m., the</p>			

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	<p>Housekeeping Supervisor indicated the laundry carts were to be covered. She further indicated Laundry Aide #50 was aware to keep the cart covered and not carry clothing against her body.</p> <p>Review of an undated policy titled, "Linen and Laundry Handling-Laundry" and provided by the Housekeeping Supervisor on 4/29/16 at 2:40 p.m., indicated the following:</p> <p>"...19. Clean linen and personal laundry items are transported to the resident's room or appropriate location on covered carts...."</p> <p>4. During a random observation on 4/27/16 at 12:26 P.M., dirty linens were on the floor next to the bed by the window in room 225. Housekeeper #23 was in the room and picked up the dirty linens from the floor and placed them in a plastic bag. She then left room 225 carrying the plastic bag and went to the soiled utility room.</p> <p>During an interview with Housekeeper #23 on 4/27/16 at 12:28 P.M., she indicated dirty laundry should not be placed on the floor and should be placed in a plastic bag and taken to the soiled utility room.</p> <p>Review of a document titled, "Linen and</p>			

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	<p>Laundry Handling - Laundry", undated, and provided by the Housekeeping Supervisor on 4/29/16 at 2:40 P.M., included the following: "...Purpose: To ensure proper handling of soiled and clean linen and personal laundry to prevent the spread of microorganisms. Standards:...3) Every effort will be made to ensure that soiled articles do not come into contact with the floor, uniforms, furniture, or other areas deemed clean... 4) Soiled linens shall be placed in plastic bags by nursing personnel..."</p> <p>3.1-18(j) 3.1-18(l) 3.1-19(g)(1)(2)(3)</p>			