

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/07/2012
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NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: January 31 and February 1, 2, 3, 7, 2012</p> <p>Facility number: 000175 Provider number: 155275 AIM number: 100274440</p> <p>Survey team: Amy Wininger, RN TC Diane Hancock, RN Barb Fowler, RN Vickie Ellis, RN</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 4 Medicaid: 54 Other: 12 Total: 70</p> <p>Sample: 15 Supplemental Sample: 14</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	Quality review completed 2/12/12 Cathy Emswiller RN			

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F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to 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 ensure 1 of 13 current residents in the sample of 15 was routinely included in care planning and had the care plan reviewed and revised when changes occurred. (Resident #2)</p> <p>Finding includes:</p> <p>On 2/1/12 at 9:35 a.m., an observation was made of Resident #2 sitting in her room in her wheelchair with a splint to her left arm. Resident #2's arm was resting on her abdomen and Resident #2's left arm was not elevated.</p> <p>On 2/1/12 at 11:45 a.m., Resident #2 was observed in the dining room in her</p>			F0280	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.F-280 comprehensive care plansIt is the intent of this facility to review and update a care plan as changes occur.A. Actions Taken:1. In regards to Resident #2, a care plan meeting was held with the resident. The care plan was updated to reflect the resident' current status.B. Others Identified:1. 100% audit was completed by the IDT to update</p>		03/08/2012

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	<p>wheelchair with a splint on her left arm, and her left arm was resting on her abdomen. Resident #2's left arm was not elevated.</p> <p>On 2/2/12 at 12:15 p.m., Resident #2 was observed in the dining room in her wheelchair with her left arm in a splint. Resident #2's left arm was not elevated. CNA#3 was observed feeding Resident #2 with a metal spoon.</p> <p>On 2/2/12 at 5:30 p.m., Resident #2 was observed in the dining room. She was being fed by LPN #2 with a metal spoon.</p> <p>The record review of Resident #2 was reviewed on 2/1/12 at 9:00 a.m. The record indicated Resident #2 had not had a care plan meeting since 07/1/11.</p> <p>A Care Plan dated 12/24/10 indicated a problem of "alteration in nutritional status" and identified interventions which included, but were not limited to, "to use a plastic spoon during meal times".</p> <p>The December 2011 Physician Order Recap indicated an order for "...keep (L) [left] arm elevated every shift."</p> <p>On 2/2/12 at 9:20 a.m. in an interview with the facility Administrator, he indicated the last care plan meeting for</p>		<p>all care plans to the residents' current status.C. Measures taken to prevent reoccurrence: 1. All Nursing staff was in-serviced on revising/updating care plans with the appropriate interventions as resident status changed.2. The IDT will audit/reise all care plans for each resident at a minimum of</p>				

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	<p>Resident #2 was on 7/1/11.</p> <p>On 2/3/12 at 9:30 a.m. in an interview with the facility Director of Nursing [DoN], she indicated Resident #2's last care plan meeting was on 7/1/11, and had Resident #2's care plans been reviewed the treatment plan of left arm elevation dated 11/03/09 and the care plan of using a plastics spoon 12/24/10 would have been removed from her record. She also indicated the care plan of using a plastic spoon was no longer needed. The DoN also indicated the treatment plan to elevate Resident #2's left arm was no longer needed.</p> <p>A document provided by the DoN titled Resident Care Manual Subject Care Plans issued 7/1/11 indicated, "It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care." It also indicated, "It is the intent of the facility for all residents to receive a review of the Plan of Care by the Interdisciplinary Team at least quarterly."</p> <p>3.1-35(d)(2)(B)</p>						

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F0282 SS=D	<p>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 ensure the written plan of care was followed, for 1 of 13 residents sampled for following the plan of care, in the sample of 15, in that a resident who was not able to see was not provided his call light at all times in accordance with his plan of care. (Resident #16)</p> <p>Finding includes:</p> <p>The clinical record of Resident #16 was reviewed on 02/02/12 at 10:00 A.M.</p> <p>During the initial tour on 01/31/12 at 1:30 P.M., the MDS [Minimum Data Set] Assessment Coordinator indicated Resident #16 was blind and not interviewable due to MR [Mental Retardation].</p> <p>The most recent MDS assessment, dated 01/09/12, indicated Resident #16 was not interviewable, required limited assist of 1 for ADL's [Activities of Daily Living], and had severely impaired vision.</p> <p>The January 2012 Physician's Order Recap indicated the diagnoses of Resident #16 included, but were not limited to,</p>			F0282	<p><b>F-282 COMPREHENSIVE CARE PLANS</b> It is the intent of the facility to follow the plan of care written for each resident. A. <b>ACTIONS TAKEN:</b> 1. In regards to Resident # 16, his chair was moved to a position close to the head of the bed and within reach of the call cord. B. <b>OTHERS IDENTIFIED:</b> 1. 100% audit/review was completed to ensure all care planned interventions were appropriate and in place. C. <b>MEASURES TAKEN:</b> 1. All Nursing staff were educated/in-serviced to facility policy in regards to appropriate interventions, updating care plans when changes occur, and ensuring all interventions are in place. 2. All CNA pocket worksheets were reviewed/updated to ensure all appropriate interventions were in place. D. <b>HOW MONITORED:</b> 1. The DON/Designee will audit/review CNA pocket worksheet in the daily QA stand-up meeting for accuracy and to ensure updates have occurred. This will be an on-going process. 2. The Adm./Designee will review all audits as completed in the monthly QA meeting with the IDT; and quarterly in the QA meeting with the Medical Director. 3.</p>		03/08/2012

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	<p>glaucoma, agitation/anxiety r/t [related to] MRDD [mental retardation developmental disability], and aggressive conduct disorder.</p> <p>A Care Plan updated 01/19/12 indicated a problem of "I am legally blind." The care plan further included approaches that included, but were not limited to, "...Place my frequently used items within reach..."</p> <p>A Care Plan updated 01/19/12 indicated a problem of "Potential for injury related to ... blind..." The care plan further included approaches that included, but were not limited to, "...call light w[with]/in reach at all times."</p> <p>On 02/01/12 at 8:10 A.M., Resident #16 was observed in his room, sitting in a chair located near the foot of the bed. The call light was observed to be out of his reach, lying on the floor near the head of the bed.</p> <p>On 02/02/12 at 11:15 A.M., Resident #16 was observed in his room, sitting in a chair located near the foot of the bed. The call light was observed to be out of his reach, lying on the floor near the head of the bed.</p> <p>On 02/03/12 at 8:00 A.M., Resident #16 was observed in his room, sitting in a</p>		<p><b>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</b></p> <p><b>DATE COMPLETED: 2-24-12.</b></p>		

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	<p>chair located near the foot of the bed. The call light was observed to be out of his reach, lying between the bed and the opposite wall.</p> <p>During an interview with the DoN [Director of Nursing] on 02/03/12 at 9:35 A.M., she stated, "...should have the call light in reach..."</p> <p>3.1-35(g)(1)</p>			
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F0314 SS=D	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident reviewed with a pressure sore, in the sample of 15, received treatment and services to promote healing and prevent new sores from developing, in that the resident was not observed to be turned and repositioned. (Resident #62)</p> <p>Finding includes:</p> <p>During the initial tour on 1/31/12 at 1:40 p.m., LPN #1 indicated Resident #62 had an open area on her coccyx that had been discovered during the previous night. She further indicated the resident had a blister on her toe they were monitoring. She indicated they used a mechanical lift to transfer the resident from the bed to the wheelchair. The resident was observed, at that time, to be up in her wheelchair. The resident remained up in her wheelchair at 2:45 p.m.</p> <p>On 2/1/12 at 9:00 a.m., Resident #62 was observed in bed, positioned on her back.</p>			F0314	<p><b>F-314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCERS</b></p> <p>The facility's intent is for residents' to receive treatment/services to heal/prevent pressure ulcers; for residents' to be turned/repositioned per their plan of care.</p> <p><b>A. ACTIONS TAKEN:</b></p> <p>1. In regards to Resident #62: the plan of care has been reviewed and updated.</p> <p><b>B. OTHERS IDENTIFIED:</b></p> <p>1. 100% audit of all residents in the facility for skin issues. No new</p>		03/08/2012

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	<p>At 9:47 a.m., the resident remained in bed on her back. At 10:30 a.m., she was observed to be up in her wheelchair. At 11:40 a.m., she continued to be up in the wheelchair. At 12:20 p.m., she was in the dining room in her wheelchair, eating lunch. At 2:00 p.m., she was back in bed, positioned on her back.</p> <p>On 2/2/12 at 10:10 a.m., Resident #62 was observed to be in bed, on her back. At 10:35 a.m., CNA #2 was observed providing morning care to Resident #62. The Treatment Nurse was observed to provide the treatment to the resident's pressure sore on the coccyx. The area was observed to be 0.8 centimeters in diameter, a Stage II area. [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough]</p> <p>Following the morning care on 2/2/12, the resident was left in bed on her back. A pillow was placed between the resident's feet, to keep her from crossing her ankles. The left heel was placed directly on the pillow. The right heel was on the bed. The resident was observed up in her wheelchair during the noon meal, at 12:30 p.m. At 3:00 p.m., the resident was observed in bed on her back. At 3:50 p.m., she was in bed on her back. At 4:42 p.m., she was in bed on her back. At 5:25</p>		<p>skin issues were identified. All residents with a high risk for skin issues would have the potential to be affected.</p> <p><b>C. MEASURES TAKEN:</b></p> <p>1. All Nursing Staff was in-serviced/educated on proper turning and positioning of dependent residents, including: monitoring turning by utilizing the T-Time QA Tool, adhering to the turning schedule per the plan of care, providing and ensuring utilization of appropriate interventions, elevating extremities, minimizing skin to skin contact, and keeping residents clean and dry. The QA CNA Pocket worksheets will be updated daily with any new interventions. This will be an on-going process.</p> <p><b>D. HOW MONITORED:</b></p> <p>1. The IDT will review the turning/repositioning schedule during QA rounds to ensure residents are all in the same direction per the schedule.</p>				

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	<p>p.m., she was in bed, on her back, being assisted with her evening meal by a family member.</p> <p>On 2/3/12 at 9:20 a.m., Resident #62 was observed to be in bed, on her back. At 10:50 a.m., she was observed being transferred to a wheelchair, positioned on her bottom. At 2:00 p.m., she continued to be in her wheelchair. At 2:25 p.m., she was in her bed, on her back, with the head of the bed elevated. CNA #2 was interviewed at that time and indicated, "I moved her around and checked her, she doesn't stand up."</p> <p>Resident #62's clinical record was reviewed on 2/1/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, a history of a pulmonary embolism, arthropathy, depression, and congestive heart failure. The most recent quarterly Minimum Data Set [MDS] assessment indicated the resident required extensive assistance of two persons for bed mobility and transfers.</p> <p>A Pressure Ulcer Risk Assessment, dated 11/2/11, indicated the resident was at moderate risk of developing a pressure ulcer.</p> <p>The resident had a care plan, initiated 1/12/2005 and reviewed 12/8/11, for</p>		<p>2. The Adm. /Designee will monitor for compliance by reviewing IDT rounds Tools in daily QA stand-up meeting.</p> <p>3. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p><b>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</b></p> <p><b>3-8-12.</b></p>		

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	<p>being at risk for pressure areas related to limited mobility, incontinence and poor nutrition. The approaches included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>-anti-pressure reducing cushion in wheelchair</li> <li>-observe skin regularly for any signs of pressure</li> <li>-pressure reducing mattress on bed</li> <li>-turn and reposition resident every 2 hours and as needed...</li> </ul> <p>Nurses' notes, dated 1/30/12 at 12:30 a.m., indicated an open area had been found on the resident's coccyx. The measurements were 0.5 centimeters [cm] by 0.2 cm by less than 0.1 cm. A physician's order, dated 1/31/12, indicated they were to clean the area with wound cleanser and use a barrier cream three times a day.</p> <p>On 2/3/12 at 3:15 p.m., the observations were review with the Director of Nurses. During interview at that time, she indicated she wasn't sure the resident would lay on her side. There was no indication it had been attempted.</p> <p>3.1-40(a)(2)</p>				

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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who had a catheter was provided services to prevent urinary tract infection and injury, in that Resident #1 experienced having a Foley catheter drainage bag held above the level of his bladder and experienced having a Foley catheter drainage tubing pulled taut and resting under his leg for 1 of 3 residents reviewed for catheters in sample of 15.</p> <p>Finding includes:</p> <p>The clinical record of Resident #1 was reviewed on 02/01/12 at 2:00 P.M. The record indicated Resident #1 had a history of urosepsis.</p> <p>During the initial tour on 01/31/12 at 1:40 P.M., upon interview at that time, the MDS [Minimum Data Set Assessment] Coordinator indicated Resident #16 was interviewable and had a catheter.</p>	F0315	<p><b>F-315 NO CATHETER, PREVENT UTI, RESTORE BLADDER</b></p> <p>The facility's intent is for residents' who require a catheter are provided services to prevent UTI's and injury.</p> <p><b>A. ACTIONS TAKEN:</b></p> <p>1. In regards to Resident #1: The catheter has been placed in the appropriate position below the level of the bladder with no restrictions to the tubing.</p> <p><b>B. OTHERS IDENTIFIED:</b></p> <p>1. A 100% audit was completed</p>	03/08/2012	

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	<p>The most recent MDS [minimum data set assessment] indicated Resident #1 had mild cognitive impairment, and had experienced an urinary tract infection in the last 30 days.</p> <p>A urine culture and sensitivity report dated 01/31/12 indicated Resident #1 had a urinary tract infection requiring antibiotic treatment.</p> <p>During an observation of a bed bath on 02/01/12 at 10:00 A.M., Resident #1 was observed to be lying on his back with the catheter tubing, taut and free of any urine, underneath his right leg. At that time, CNA #6 was observed to remove the tubing from under the Resident's leg, and release the tension of the Foley catheter. The tubing was immediately observed to fill with urine and bleeding was observed from the meatus of the penis. At that time, Resident #1 indicated, "Ouch, that hurts!"</p> <p>LPN #3 was summoned to the resident's room to assess the resident. During an interview on 02/01/12 at 10:20 A.M., LPN #3 indicated, "That looks like it has been pulled...he has a UTI [urinary tract infection]...that looks like he has been laying on the catheter..."</p> <p>Care was observed to resume on 02/01/12</p>		<p>for all residents with a catheter. No other residents were identified. All residents with a catheter would have the potential to be affected.</p> <p><b>C. MEASURES TAKEN:</b></p> <ol style="list-style-type: none"> <li>All Nursing Staff was in-serviced/educated on proper positioning of a catheter, including: monitoring for appropriate placement below the level of the bladder, no obstructions and/or kinks to prevent drainage, how to reposition or transfer a resident with a catheter to maintain below level of bladder, and to avoid pulling on the catheter during cleansing.</li> <li>Licensed nurses will monitor/audit during their rounds that all residents with catheters have their catheters appropriately placed below the level of the bladder with no obstruction to drainage. This will be documented on the 24 hour report. This will be an on-going process.</li> </ol>				

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	<p>at 10:30 A.M., CNA #3 and CNA #6 were observed to assist Resident #1 into the supine position. During the repositioning CNA #3 was observed to hold the Foley catheter drainage bag above the level of the resident's bladder.</p> <p>A policy and procedure for "Catheterization Urinary Catheter Insertion/Catheter Care, dated 01/07, was provided by the DoN [Director of Nursing] on 02/07/12 at 11:30 A.M. and indicated, "Procedure...7....keeping the drainage system free of kinks in the tubing, maintain below the level of the bladder...8...Avoid pulling on the catheter during cleansing..."</p> <p>3.1-41(a)(2)</p>		<p>D. HOW MONITORED:</p> <ol style="list-style-type: none"> <li>The IDT will review the positioning of catheters during QA rounds to ensure residents with catheters have their catheters positioned correctly with no prevention of drainage. This will be an on-going process.</li> <li>The DON/Designee will review all licensed nurse audits per the 24 hour report daily in the QA stand-up meeting for on-going compliance.</li> <li>The Adm. /Designee will monitor all audits as completed for compliance by reviewing; i.e., licensed nurse audits, and IDT rounds Tools, in daily QA stand-up meeting.</li> <li>The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</li> </ol>		

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			<p><b>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</b></p> <p><b>3-8-12.</b></p>	
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F0323 SS=D	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on record review and interview, the facility failed to ensure adequate supervision to prevent accidents, for 1 of 5 residents sampled with falls, in the sample of 15, in that the resident was left in the shower room unattended and fell. (Resident #60)</p> <p>B. Based on observation and interview, the facility failed to ensure the therapy room was locked when unattended, during 1 of 5 observations, with the Hydroculator containing hot water. This had the potential to affect 2 of 2 residents on the East Front Hall who were mobile in their wheelchairs and cognitively impaired. (Residents #47, #12)</p> <p>Findings include:</p> <p>A1. Resident #60's clinical record was reviewed on 2/2/12 at 2:00 p.m. The Minimum Data Set [MDS] assessment, dated 12/1/11, indicated Resident #60 was alert and oriented. It also indicated Resident #60 needed extensive assistance of bathing with 1 staff member assist.</p> <p>A nursing summary assessment of Resident #60, dated 12/1/11, indicated</p>			F0323	<p><b>F-323 ACCIDENTS AND SUPERVISION</b></p> <p>The facility's intent is to have adequate supervision to prevent falls; and for the therapy room to be locked when unattended to prevent possible injury to cognitively impaired residents.</p> <p>A. <b>ACTIONS TAKEN:</b></p> <p>1. In regards to Resident #60: CNA #4 was educated/in-serviced on following the plan of care for residents and not leaving a resident unattended in the shower room.</p> <p>2. In regards to Residents #12 and #47: the Therapy Room will be locked when no staff are in the room.</p> <p>B. <b>OTHERS IDENTIFIED:</b></p>		03/08/2012

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	<p>Resident #60 was able to make her needs known and was a total assist with bathing and hygiene.</p> <p>The nurses notes dated 1/6/12 indicated LPN #2 was summoned to the shower room, where Resident #60 was found lying on her right side on the floor without injury.</p> <p>The fall risk assessment dated 11/29/11 indicated Resident #60 had a fall risk score of 11 with 10 or above representing high risk.</p> <p>A care plan for risk of falls, with no initiation date, indicated Resident #60 was a 1-2 assist with all transfers and had an intervention on 1/6/12 to not be left unattended in the shower.</p> <p>In an interview with Resident #60 on 2/3/12 at 9:30 a.m., Resident #60 indicated CNA #4 was giving her a shower, when CNA #5 asked for CNA #4's assistance in another room. CNA #4 left Resident #60 in the shower on a shower chair by herself. Resident #60 then explained she reached over to pull the call light from the shower chair and fell in the floor hitting her head.</p> <p>In an interview on 2/3/12 at 10:00 a.m., the DoN [Director of Nursing] indicated,</p>		<p>1. All residents with a high risk for falls would have the potential to be affected.</p> <p>2. All cognitively impaired residents would potentially be affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. All Nursing Staff was in-serviced on following a residents' plan of care. No resident should be left unattended in the shower room.</p> <p>2. The CNA QA pocket worksheets were audited to ensure all information and interventions were correct.</p> <p>3. All Therapy staff was in-serviced/educated in regards to locking the door to their Therapy Room if there is no one left in the room to ensure the safety of residents.</p>				

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	CNA #5 needed assistance. CNA #4 left Resident #60 in the shower room alone to assist CNA #5, and Resident #60 fell while left unattended.		<p>D. <b>HOW MONITORED:</b></p> <p>1. The Nurses will monitor during showers for compliance by signing shower sheets that staff remained with residents. The shower sheets will be reviewed in daily QA stand-up meeting for compliance.</p> <p>2. The QA/IDT will monitor throughout the day every day for compliance with closing and locking the Therapy Room door if no Therapy staff are in the room. If found unlocked and unattended it will be locked.</p> <p>3. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. <b>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:</b></p>		

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	<p>B. During observation on 2/3/12 at 2:18 p.m., the physical therapy room was unlocked and unattended with the door open. Inside the room there was a Hydroculator containing hot packs submerged in water. The temperature of the water measured 172 degrees Fahrenheit. No residents were observed in the room or in the area of the Hydroculator at that time.</p> <p>At 2:20 p.m. on 2/3/12, Physical Therapy Assistant [PTA] #1 entered the room. When queried about the room being unattended and unlocked, she indicated there was usually someone in the room. She indicated it was not their routine to lock the door until the end of the day. She then locked the door as she left.</p> <p>LPN #1, the nurse for the hall with the therapy room on it, was interviewed at 2:25 p.m. She indicated they didn't currently have residents who wandered in and out of rooms. She did indicate there were two residents who wheeled around the hallways, who were cognitively impaired. Those residents were identified as Resident #47 and #12.</p>		3-8-12				

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	3.1-45(a)(1) 3.1-45(a)(2)			

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F0328 SS=D	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based upon observation, record review, and interview, the facility failed to do proper assessment and documentation of a resident receiving nebulizer treatment, for 1 of 1 resident observed receiving a nebulizer treatment during the medication pass, in that lung sounds, heart rate, respiratory rate, and resident tolerance were not assessed before and after the treatment. (Resident #59)</p> <p>Finding includes:</p> <p>During observation on 2/3/12 at 8:30 A.M., LPN #5 administered a Duoneb [combination of respiratory medications] treatment through a nebulizer to Resident #59. The resident was not assessed before or after administration of the nebulizer treatment nor did the nurse stay in the room with the resident during the treatment.</p> <p>On query of the DoN [Director of Nursing] on 2/7/12 at 11:45 a.m., the</p>	F0328	<p><b>F-328 TREATMENT/CARE FOR SPECIAL NEEDS</b></p> <p>The facility's intent is to provide the proper assessment, including lung sounds, heart rate, respiratory rate, and appropriate documentation, including assessing tolerance before and after the treatment, for all residents receiving nebulizer treatments.</p> <p>A. <b>ACTIONS TAKEN:</b></p> <p>1. In regards to resident #59: LPN #5 was in-serviced/educated on appropriate steps for assessing the resident prior to and after a nebulizer treatment and also in the appropriate documentation following the treatment, including the residents' tolerance before and after the treatment.</p>	03/08/2012			

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	<p>DoN indicated the nurse who administers the nebulizer treatment had been inserviced to stay in the room with the resident while they were receiving the treatment and the nurse was to assess before and after giving the treatment. The DoN also indicated the nurse was to document on the "HHN [Hand Held Nebulizer] Treatment Record" the "date, time, lung sounds before TX, respiratory rate, tolerance/comments, lung sounds after TX respiratory rate after, minutes, and signature for each treatment."</p> <p>On record review on 2/7/12 at 11:45 a.m., there was no documentation of assessment before or after giving the nebulizer treatment in the nurse's notes and no HHN treatment record was found in the MAR [Medication Administration Record] book, the Treatment Administration Record book, or in Resident #59's clinical record.</p> <p>3.1-47(a)(6)</p>		<p><b>B. OTHERS IDENTIFIED:</b></p> <p>1. This concern would have the potential to affect all residents' receiving nebulizer treatments.</p> <p><b>C. MEASURES TAKEN:</b></p> <p>1. The Licensed Nursing staff will be in-serviced on appropriate assessment of a resident prior to a nebulizer treatment, monitoring during the treatment, and appropriate assessment and documentation following the treatment.</p> <p>2. Each licensed nurse will perform a return demonstration of an appropriate assessment prior to a nebulizer treatment, an appropriate assessment of tolerance following a nebulizer treatment, and an appropriate documentation of the assessments including tolerance. Thereafter there will be a minimum of one annual observed demonstration for each nurse to ensure competency.</p>	
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			<p>D. <b>HOW MONITORED:</b></p> <p>1. The DON/Designee will audit/monitor one random nebulizer treatment daily for two weeks on different shifts; which will include assessment and documentation.</p> <p>2. The CEO/Designee will review audits as completed in the daily QA stand-up meeting with the IDT; in the monthly QA meeting with the IDT; and quarterly in the QA meeting with the Medical Director.</p> <p>E. <b>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:</b></p> <p><b>3-8-12.</b></p>		

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F0332 SS=E	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure it was free of medication errors, for 4 of 16 residents observed during medication administration (Residents #3, #61, #45, #15) by 2 of 6 nurses observed (RN #1, LPN #4). There were 6 errors and 45 opportunities for errors, resulting in an error rate of 13.30 percent.</p> <p>Findings include:</p> <p>1. On 2/3/12 at 11:23 a.m., LPN #4 was observed giving the medication Diazepam [anti-anxiety medication] 2 milligrams [mg] and Baclofen [anti-spasmodic medications] 5 mg to Resident #61.</p> <p>A record review on 2/3/12 at 3:00 p.m. indicated a physician's order signed 1/30/12 for Diazepam 2 mg by mouth three times a day 8:00 a.m., 2:00 p.m., and 8:00 p.m., and a physician's order signed 1/30/12 for Baclofen 10 mg a half a tab by mouth three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m.</p> <p>2. On 2/3/12 at 11:40 a.m., LPN #4 was observed giving the medication Dilantin [anti-seizure medication] 100 mg by mouth to Resident #45.</p>	F0332	<p><b>F-332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b> The facility's intent is to have a medication error rate of less than 5%.  <b>A. ACTIONS TAKEN:</b> 1. In regards to residents' #3, #61, #45, #15: LPN #4 and RN #1 were counseled and in-serviced/educated in the five (5) rights of a medication pass, and the appropriate time frame for administering scheduled medications.  <b>B. OTHERS IDENTIFIED:</b> 1. This concern would have the potential to affect all residents.  <b>C. MEASURES TAKEN:</b> 1. All Licensed Nursing staff will be in-serviced on the appropriate time frames for administering scheduled medications and the (5) five rights of a medication pass. 2. Each licensed nurse will be observed during a medication pass by the DON/Designee by the compliance date to ensure compliance with the 5 rights and the appropriate time frame for medication administration. Thereafter there will be a minimum of one annual observed demonstration for each nurse to ensure competency.  <b>D. HOW MONITORED:</b> 1. The DON/Designee will, after completion of all nurses' during an observed medication pass, audit/monitor one random</p>	03/08/2012			

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	<p>A record review on 2/3/12 at 3:05 p.m. indicated a physician's order signed 1/31/12 for Dilantin 100 mg 1 tab by mouth three times a day at 7:00 a.m., 1:00 p.m. and 7:00 p.m.</p> <p>3. On 2/3/12 at 11:45 a.m., LPN #4 was observed giving Carbidopa/Levodopa [anti-Parkinson] 25 mg/100 mg by mouth to Resident #15.</p> <p>A record review on 2/3/12 at 3:07 p.m. indicated a physician's order signed 1/8/12 for Carbidopa/Levodopa 25/100 mg give 1 tab by mouth three times a day at 7:00 a.m., 1:00 p.m., and 7:00 p.m.</p> <p>In an interview with the DoN on 2/3/12 at 3:30 p.m., she indicated it was this facility's policy to give medications between the hours of 1 hour prior or 1 hour past the scheduled medication time.</p> <p>4. On 2/3/12 at 4:20 P.M., Resident #3 was observed being given Artificial Tears Ophthalmic Solution 1 drop to each eye, by RN #1.</p> <p>Resident #3's record was reviewed on 2/3/12 at 4:25 P.M. The physician's order for Artificial Tears Ophthalmic Solution, signed by the physician on 1/8/12, indicated that 2 drops were to be inserted</p>		<p>medication pass weekly for four weeks on different shifts. All observations will be reviewed in the daily QA stand-up as completed. 2. The CEO/Designee will review audits as completed; in the monthly QA meeting with the IDT; and quarterly in the QA meeting with the Medical Director. <b>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: 3-8-12.</b></p>	
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	<p>to each eye. The Medication Administration Record [MAR] indicated that the medication was to be given at 7:00 A.M., 11:00 A.M., and 7:00 P.M.</p> <p>During an interview on 2/3/12 at 4:20 p.m., RN #1 indicated that she inserted only 1 drop to both eyes of Resident #3 and the time had been changed of when the eye drops were to be given. Upon further query, RN #1 indicated that she had forgotten the eye drops were to be inserted at 7:00 P.M. instead of 4:00 P.M. and that the times had not been changed.</p> <p>According to the facility policy for medication administration, dated 1/1/05, provided by the Director of Nursing on 2/7/12 at 8:30 a.m., medications are administered to the resident as close as possible to the prescribed time and always within 60 minutes of the scheduled time and the nurse will check the medication dose to assure every medication is administered correctly. The facility policy indicated the nurse should check the medication 3 times before administering the medication.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			
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F0363 SS=E	<p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview and record review, the facility failed to ensure recipes were followed for 7 of 7 pureed diets, in that a recipe for 15 servings was referred to, when making 8 servings.</p> <p>Finding includes:</p> <p>On 2/3/12 at 10:35 a.m., Cook #1 was observed preparing pureed fish. She indicated she was making 8 servings, because they needed 7. She indicated there were 4 regular puree diets and 3 residents who received pureed meat.</p> <p>The Cook was observed to refer to a puree fish recipe for 15 servings. She placed 8 pieces of breaded fish into the RobotCoupe. She placed 8 slices of bread and 1 quart of water into the RobotCoupe. She then used a small dining spoon to get 3 spoonfuls of chicken base and placed the base in the RoboCoupe. She then pureed the items in the machine. The resulting product was very stiff.</p> <p>The recipe the Cook referred to was reviewed, at that time, and indicated, for</p>			F0363	<p><b>F-363 MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</b></p> <p>It is the intent of this facility for recipes to be followed for pureed diets.</p> <p><b>A. ACTIONS TAKEN:</b></p> <p>1. In regards to the seven (7) residents identified: The dietary staff was in-serviced on following recipes for Pureed diets and calculating for the appropriate servings needed.</p> <p><b>B. OTHERS IDENTIFIED:</b></p> <p>1. All residents receiving a Pureed diet would be affected.</p>		03/08/2012

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	<p>15 servings there were to be 15 servings of fish, 7 and 1/2 slices of bread, 1 quart and 2 cups of water, and 2 tablespoons of chicken base.</p> <p>The Cook was then observed to refer to a recipe for pureed french fries. It was for 15 servings; she indicated they only needed 4.</p> <p>During an interview on 02/03/12 at 10:45 a.m. with the Dietary Manager, she indicated she would have to figure the recipes for a smaller number of servings.</p> <p>3.1-20(i)(4)</p>		<p><b>C. MEASURES TAKEN:</b></p> <p>1. The Dietary staff was in-serviced to facility policy in regards to following recipes when preparing pureed meals; and how to appropriately calculate for desired servings.</p> <p>2. The Dietary Manager/Designee will directly observe/audit preparation of Pureed diets daily for two weeks for two of three random meals. Then at a minimum of one random meal per day per week to ensure compliance. This will be an on-going process.</p> <p>3. RD will audit/observe Pureed diet preparation during visit and include results of observation/audit in Dietary Report with visits on a monthly basis for six (6) months.</p> <p><b>D. HOW MONITORED:</b></p> <p>1. The Dietary</p>		

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			<p>Manager/Designee will review audit results in daily QA stand-up meeting with IDT team.</p> <p>2. Adm. /Designee will review all audits in the daily QA stand-up meeting; monthly at QA meeting with the IDT; and quarterly in QA meeting with the Medial Director.</p> <p>E. <b>DATE COMPLETED:</b> 3-8-12.</p>	

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F0364 SS=E	<p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation and interview, the facility failed to ensure food was served at a palatable temperature, for 10 of 10 residents in the group interview and 1 of 2 residents randomly interviewed during meal service and for 2 of 3 meals observed (evening meal 2/2/12, noon meal 2/3/12). (Residents #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81)</p> <p>Findings include:</p> <p>1. During the group interview, on 2/1/12 at 2:05 p.m., 10 of 10 alert and oriented residents complained of often getting cold food. (Residents #71, #72, #73, #74, #75, #76, #77, #78, #79, #80)</p> <p>2. On 2/2/12 at 5:10 p.m., the last tray had been served on the East Front Hall. Temperatures were checked on a tray on the cart that was not needed. The milk was 48 degrees Fahrenheit. The hamburger was 104 degrees Fahrenheit. The potatoes were 100 degrees Fahrenheit.</p> <p>One of two residents interviewed on that hall (Resident #81), at 5:15 p.m., indicated the food had been cool.</p>			F0364	<p><b>F-364 FOOD</b></p> <p>It is the intent of the facility for each resident to receive meal trays at a palatable temperature.</p> <p><b>A. ACTIONS TAKEN TO CORRECT:</b></p> <p>1. In regards to all residents' identified: Temperatures of trays will be monitored daily at all meals.</p> <p><b>B. OTHERS IDENTIFIED:</b></p> <p>1. All residents would be affected.</p> <p><b>C. MEASURES TAKEN:</b></p> <p>1. The Dietary staff was in-serviced to facility policy in regards to appropriately taking</p>		03/08/2012

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	<p>At 5:25 p.m. on 2/2/12, the last tray was served on the East Back Hall. The temperatures were checked on an extra tray on the cart at that time. The meat registered 98 degrees F., the potatoes were 96 degrees, the milk was 54 degrees, and the ice cream sandwich was soft to touch.</p> <p>3. On 2/3/12 at 12:05 p.m., the last tray had been served on the West Back Hall. The french fries measured 101 degrees Fahrenheit, the tartar sauce measured 55 degrees.</p> <p>3.1-21(a)(2)</p>				<p>temperatures of food prior to service and keeping the log.</p> <p>2. The Dietary Manager/Designee will take the temperature of all foods prior to meal service, and the last tray set up, to ensure appropriate temperature is maintained. This will be an on-going process.</p> <p>3. Adm. /Designee will take food temperatures daily of last tray for one random meal to ensure appropriate temperature is sustained during meal service.</p> <p>4. The Adm. and/or Department Head will taste a sample tray of all items served daily for compliance with plan of correction for appropriate temperature; a log will be maintained of the person who sampled the tray and their comments in regards to temperature, consistency, and appropriate seasonings. This will be an on-going process.</p> <p>D. HOW IT WILL BE MONITORED:</p>		

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			<p>1. The Dietary Manager/Designee will review audit results in daily QA stand-up meeting with IDT team.</p> <p>2. Adm. /Designee will review all audits in the daily QA stand-up meeting; monthly at QA meeting with the IDT; and quarterly in QA meeting with the Medial Director.</p> <p>E. <b>DATE COMPLETED:</b> 3-8-12.</p>	

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure infection control procedures were followed in the care of 3 of 7 sampled</p>	F0441	F-441 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the intent of this facility for the Infection Control procedures are followed during the use of	03/08/2012
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	<p>residents observed during care, in the sample of 15, and for 3 of 3 supplemental sample residents observed during care, in the supplemental sample of 14, in that a glucometer was not sanitized after use, glove use and handwashing was not done as required, and dressing changes were not completed as required. (Residents #39, #12, #34, #6, #1, #64)</p> <p>Findings include:</p> <p>1. On 2/2/12 at 4:17 p.m., LPN #2 was observed performing a blood sugar check on Resident #39. She obtained the reading and then returned the glucometer to the medication cart and laid it on the top surface. After giving Resident #39 her insulin, she prepared to enter the room of Resident #64 to obtain a blood sugar check. She put on gloves, got a test strip ready, picked up the glucometer and was entering the next room when she was stopped.</p> <p>During an interview at that time, LPN #2 indicated they routinely cleaned them between residents and she had forgotten. She then obtained an alcohol swab and began to wipe down the meter. Upon further questioning, she indicated the "company tells us to use these, (pointing to hospital grade disinfecting wipes in the top drawer of the medication cart), but I</p>		<p>Glucometers, and dressing changes. A. ACTIONS TAKEN: 1. In regards to Resident # 39; LPN #2 was counseled, educated/in-serviced on appropriate cleansing of a Glucometer between residents, allowing to air dry before using again, and utilizing both Glucometers that are on the medication cart. 2. In regards to Resident #12, CNA #2 was counseled, educated/in-serviced on appropriate hand washing, changing of gloves between tasks, when touching any item that may be contaminated, and sanitizing any table contaminated. 3. In regards to Resident #6: All licensed nurses' were in-serviced on appropriate weekly changing of a PICC line dressing, placing the date of the dressing change on the dressing, and potential for infection due to inappropriate care of a PICC line dressing. B. OTHERS IDENTIFIED: 1. All residents would have the potential to be affected. C. MEASURES TAKEN: 1. All Nurses will be in-serviced on appropriate weekly change of a PICC line dressing, including placing the date of the dressing change on the dressing, and the potential for infection due to inappropriate care of a PICC line. 2. All Nurses will be in-serviced on appropriate use of Glucometers, use of appropriate cleansing/disinfecting wipes and allowing to air dry between uses,</p>	

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	<p>don't like them." She indicated they left a lot of fluid on the meters and after drying left a film on the meter. She then wiped down the meter with the disinfectant and left it to dry on the medication cart.</p> <p>On 02/03/12 at 9:00 a.m., the Director of Nurses was informed of the observation. At that time, she indicated it was not their policy to use alcohol and LPN #2 had been informed of that and signed in-service records.</p> <p>The policy and procedure for Glucometer Cleaning, dated 7/1/11, was provided by the Director of Nurses on 2/7/12 at 8:55 a.m. The intent of the policy was to properly sanitize glucometers between resident use. The procedure included, but was not limited to, "Complete sanitization of glucometers by wiping with approved disposable wipes between resident use...there should be 2 glucometers per medication cart--one in use and one cleaned and drying..."</p> <p>2. On 2/1/12 at 11:10 a.m., CNA #2 was observed providing morning care to Resident #12. The bath water was placed on the overbed table. During the bath, the CNA was observed to place a used wash cloth on the overbed table. Following the bath, the bath water was disposed of and the overbed table was moved back into its</p>		<p>and utilizing two Glucometers on each medication cart to ensure adequate time for air drying.</p> <p>3. All CNA's will be in-serviced on providing personal care (showers, baths, peri-care, etc.) to residents, appropriate glove usage, appropriate hand washing, appropriate times to change gloves and/or wash hands, per the CNA Training Manual. 4. All Nurses will perform an observed blood sugar, and cleansing/disinfecting of the Glucometer to ensure competency. This will be repeated at a minimum of annually to ensure continued competency. D. HOW MONITORED: 1. Don/Designee will audit PICC line dressing change weekly for compliance and will audit dressing itself for date of change. This will be an on-going weekly audit until determined otherwise by the QA Committee. 2. DON/Designee will do random audit daily on various shifts/carts for one week of Glucometer usage to ensure appropriate cleansing/disinfecting of the Glucometer; then random audits weekly x 4 weeks; then random monthly audit x 3 months; then a quarterly random audit which will continue as an on-going audit. 3. DON/Designee will do random daily audit of personal care (shower, bath, peri-care) on each shift x 1 week; then random weekly audit on each shift x 2</p>		

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	<p>original position. The table had areas of wetness on it. She obtained a paper towel and dried off the table. There was no sanitization of the overbed table.</p> <p>3. Resident #34 was observed during a shower on 2/1/12 at 8:25 A.M., provided by CNA #1. Resident #34 was brought to the shower room in her wheelchair. While in the shower room, CNA #1 applied gloves without washing her hands. Resident #34 was stood and her clothing and soiled undergarment were removed. Resident #34 was assisted onto the shower chair. CNA #1 then placed the resident into the shower stall and turned on the water. CNA #1 washed Resident #34 's hair and body including the resident's peri-area while wearing the same gloves. After completing the shower, CNA #1 removed the resident from the shower stall. While sitting on the shower chair, the resident was incontinent of stool onto the floor of the shower room. CNA #1 applied Resident #34's clothing, body spray, deodorant, and lotion while wearing the same gloves that she wore while giving the shower. Resident #34 was transferred back into her wheelchair using a gait belt by CNA</p>		<p>weeks; then an on-going random audit monthly on each shift to ensure compliance with standard of care. 4. The Adm. /Designee will review all audits as completed in the weekly QA meeting; monthly in the QA meeting with the IDT; and quarterly in the QA meeting with the Medical Director. E. DATE COMPLETED: 3-8-12.</p>		

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	<p>#1. CNA #1 cleaned the floor, wearing the same gloves, with a paper towel. After cleaning the floor, CNA #1 removed her gloves and washed her hands.</p> <p>Upon query at that time, CNA #1 indicated she was to clean up visible soiling on the floors and notify the housekeeping department to clean the floor thoroughly.</p> <p>Upon review of the Handwashing Policy, dated 7/1/11 and provided by the Director of Nursing on 2/7/12 at 8:55 a.m., the guideline stated that "it is the intent of the facility to use proper handwashing technique to prevent the spread of infection as per Center of Disease Control Guidelines."</p> <p>4. Resident #6's clinical record was reviewed on 2/2/12 at 2:15 p.m. Resident #6 had a PICC [Percutaneous Inserted Central Catheter] inserted on 1/4/12. The physicians order dated 1/4/12 indicated "PICC drsg changes and care per protocol." According to the resident's nurses notes and MAR [Medication Administration Record], the PICC dressing was changed on 1/21/12 and 1/30/12. According to the facility policy on PICC dressing change, the PICC dressing is to be changed "at least</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/07/2012
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	<p>weekly" and "if the integrity of the dressing has been compromised."</p> <p>Resident #6's PICC dressing was observed on 2/3/12 at 2:30 p.m. It had no date on it.</p> <p>Upon query, the DoN [Director of Nursing] indicated the PICC dressings are to be changed weekly and as needed if soiled.</p> <p>5. The clinical record of Resident #1 was reviewed on 02/01/12 at 2:00 P.M. The record indicated Resident #1 had a history of morbid obesity and urosepsis.</p> <p>During the initial tour on 01/31/12 at 1:40 P.M., the MDS [Minimum Data Set] Assessment Coordinator indicated Resident #1 was interviewable, required the assistance of one to two staff for care, and had a catheter.</p> <p>The most recent MDS assessment dated 11/07/11 indicated Resident #1 had mild cognitive impairment, and had experienced an urinary tract infection in the last 30 days.</p> <p>A urine culture and sensitivity report dated 01/31/12 indicated Resident #1 had a urinary tract infection requiring antibiotic treatment.</p>				

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	<p>During an observation of a bed bath on 02/01/12 at 10:00 A.M., CNA #6 was observed to wash the perineal area of Resident #1 and then dry the skin folds of the upper body without changing gloves. CNA #6 was then observed to apply powder to upper body skin folds and groin folds then apply a clean gown without removing the contaminated gloves.</p> <p>During an interview on 02/01/12 at 10:15 A.M. CNA #3 stated, "You are supposed to wash hands and change gloves in between clean and dirty..."</p> <p>A policy and procedure for Standard Precautions provided by the DoN on 02/07/12 at 12:15 P.M., indicated, "...Procedure: I. Standard Precautions...B. Gloves...Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms..."</p> <p>3.1-18(b)(1)</p>				