

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2014
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NAME OF PROVIDER OR SUPPLIER ADAMS WOODCREST	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 7, 8, 11, 12, 13, and 14, 2014.</p> <p>Facility number: 000556 Provider number: 155747 AIM number: 100290130</p> <p>Survey Team: Virginia Terveer, RN, TC Sue Brooker, RD Julie Call, RN Martha Saull, RN (August 7,8,11, 12, and 13, 2014)</p> <p>Census bed type: SNF/NF: 120 Total: 120</p> <p>Census Payor type: Medicare: 23 Medicaid: 53 Other: 44 Total: 120</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 19,</p>	F000000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Adams-Woodcrest maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Adams-Woodcrest asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's credible allegation of compliance and, thereby, we request resurvey to verify such as of September 04, 2014. Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated or accomplished corrective action. These do not</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000156 SS=C	<p>2014 by Randy Fry RN.</p> <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</p>		necessarily chronologically correspond to the date that Adams-Woodcrest is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.		

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	<p>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: 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</p>						

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	<p>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, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation, interview and record review the facility failed to ensure the Indiana State Department of Health's (ISDH) toll free phone number to file a complaint was displayed clearly for Residents, Families and Visitors to view with a potential to affect all of the resident in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 8/7/14 at 12:30 p.m., the ISDH Compliant toll free phone number could not be located in the long term healthcare area of the facility.</p> <p>During an observation on 8/14/14 at 10:30 a.m., in the main entrance of AECC (the Skilled Nursing Unit), the facility's posting for the ISDH Complaint toll free phone number was found to be in a picture frame hanging on the wall. The toll free number for complaints was hung at a measurement of 4' 10" and another at 6' 3.5" from the floor. The phone</p>	F000156	<p>F156 It is the policy of this provider to 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. As well, to post names, addresses and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency; the State licensure agency; the State ombudsman program; the protection and advocacy network; the Medicaid fraud control unit and a statement that the resident can file a complaint with the State survey and certification agency concerning abuse, neglect and misappropriation of resident property in the facility and non-compliance with advance directives. <u>What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> No residents were identified. <u>How will the facility identify other residents having the</u></p>	09/04/2014

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	<p>numbers could not easily be seen when seated in a wheelchair.</p> <p>An interview with the DON (Director of Nursing) on 8/14/14 at 11:00 a.m., indicated there was a list of advocate phone numbers on the bulletin boards in the A and C wings of the facility. The list of Resident Rights Advocates was reviewed and the DON indicated the ISDH Complaint toll free number was not listed on the document.</p> <p>An interview with the Administrator on 8/14/14 at 11:10 a.m., indicated the posted information for ISDH phone numbers was removed from the main entrance of Healthcare. He indicated he did not know the current location of the ISDH Complaint toll free phone number but the residents are given the phone numbers on admission to the facility.</p> <p>An interview with the Administrator on 8/14/14 at 11:15 a.m., when he viewed the framed ISDH phone numbers hanging near the entrance of AECC, indicated the phone numbers were hung too high on the wall for viewing and should be moved lower on the wall.</p> <p>On 8/14/14 at 1:45 p.m., the DON provided the Facility's Policy, titled, Resident Rights, with a revised date of</p>		<p><u>potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> The number 800-249-8909 will remain posted. <u>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The number will remain posted. <u>How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> The number will remain posted. Expected date of completion – 08/14/2014</p>				

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F000282 SS=D	<p>10/11 which indicated, "...Notice of rights and services...The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights...Such notification must be made prior to or upon admission and during the resident's stay....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...."</p> <p>3.1-4(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 interview and record review, the facility failed to follow a physician</p>	F000282	F282 It is the policy of this provider to ensure that the services provided	09/04/2014

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	<p>order for a Posey alarm in bed for 1 resident (Resident #105) of 35 residents reviewed for physician orders.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #105 on 8/11/14 at 11:21 a.m., indicated the following: diagnoses included, but were not limited to, lung cancer with brain metastasis, frequent falls, hypertension, PVD (peripheral vascular disease), chronic pain, organic insomnia, macular degeneration of retina, depressive disorder, and dementia with behavioral disturbances.</p> <p>A Minimum Data Set (MDS) assessment for Resident #105, dated 11/25/13, indicated a score of 11 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The MDS also indicated he required extensive assistance with the physical assistance of 1 person for transfers and walking in room. The MDS further indicated he was not steady, only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around, moving on and off toilet, and surface-to-surface transfer. The MDS also indicated a walker and wheelchair were normally used by Resident #105.</p>		<p>by or arranged by the provider are rendered by qualified personnel and in accordance with the resident's written care plan.</p> <p><u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident #105 will have the alarm in place in accordance with the physician's order.</p> <p><u>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</u></p> <p>Other residents having the propensity to be affected by the alleged deficient practice would be identified as those residents with a physician's order for an alarm. Those so identified will have the alarm in place in accordance with the physician's order.</p> <p><u>What measures will be put into place or what systemic changes</u></p>				

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	<p>A Physician's order for Resident #105, dated 12/4/13, indicated a Posey alarm on when in bed and chair to alert staff of independent transfers (frequent falls).</p> <p>A Fall Risk Assessment for Resident #105, dated 12/7/13, indicated he was at high risk for falls.</p> <p>A Nursing Progress Note for Resident #105, dated 12/8/13 at 7:02 a.m., indicated he sustained a fall at 4:45 a.m. The note also indicated he was found lying on his left side with a walker clenched at both sides. Resident #105 appeared to be alert and oriented times three. The note further indicated the left foot was rotated to the side with pain on movement of the left leg and severe pain on standing up. The note also indicated the physician was called and an order was received to send him to the hospital for evaluation, possible admit, and treatment.</p> <p>A Nursing Note for Resident #105, dated 12/8/13 at 7:33 a.m., indicated his roommate went outside of his room and told staff members "we got a man down in here." The note also indicated the resident was found lying on his left side with his walker turned over at his doorframe of the bathroom. The note further indicated upon assessment his left</p>		<p><u>will be made to ensure that the deficient practice does not recur?</u></p> <p>Nursing staff members have received training related to the placement of alarms per physician's order.</p> <p><u>How will the corrective actions be monitored to ensure the deficient practice does not recur?</u></p> <p>Director, Nursing Service /Designee will audit the placement of the alarms Monday to Friday all 3 shifts for one month initially and once weekly on 3 shifts thereafter for 5 months to ensure that the resident's care plan as mentioned and physicians' order for alarms are being followed. A summary report will be forwarded for inclusion in the monthly QAA/PI meeting. The QAA/PI Committee will review the summary from above and make recommendations to the Director of Nursing based on the summaries for continued monitoring going forward past 6 months.</p> <p><u>By what date will the systemic changes be completed?</u></p>				

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	<p>foot was slightly rotated to the left side. The note also indicated the hip felt in place but the resident had severe pain on little movement of the left leg with a rotated foot, and severe pain as he was briefly placed in a standing position. His physician was notified and an order was received to send the resident to the ER (Emergency Room). The note also indicated "It was then reported to writer that (resident's name's) posey alarm was hooked up to his recliner but not his actual bed from which he was transferring self to restroom from."</p> <p>A physician's order for Resident #105, dated 12/8/13, indicated to send to ER for evaluation, treatment, and possible admission (fall, possible broken hip).</p> <p>A Nursing Progress Note for Resident #105, dated 12/8/13 at 7:52 a.m., indicated the hospital ER was called and the facility was informed the resident did indeed suffer a broken left hip. The note also indicated he would be admitted to the hospital.</p> <p>An Emergency Room Report for Resident #105, dated 12/8/13, indicated he was brought to the ER with the chief complaint of left hip pain from a fall. The report also indicated the radiographs of the left hip showed a complete</p>		09/04/2014	

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	<p>displaced angulated left femoral neck fracture. The report further indicated Resident #105 was admitted to the hospital for surgery.</p> <p>A Fall Investigation for Resident #105, dated 12/10/13, indicated his roommate was asking for assistance when the Certified Nursing Assistant entered the room and observed the resident on the floor. The investigation also indicated the nurse entered the room and observed the resident lying on his left side on the floor in the bathroom. The investigation further indicated the resident complained of pain in his left hip and leg region. Orders were given to send the resident to the hospital ER for evaluation. The investigation also indicated the nurse was interviewed and stated "I checked the alarm once the resident was transferred to the hospital and observed the posey box alarmed to the chair pad and not the pad in his bed."</p> <p>The DON was interviewed on 8/12/14 at 2:42 p.m. During the interview she indicated the Posey alarm should have been on his bed.</p> <p>A current facility policy "Resident Alarms for Safety", revised on May, 2013 and provided by the Staff Development Coordinator on 8/13/14 at 10:15 a.m.,</p>			

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F000315 SS=D	<p>indicated "...Resident alarms may be used for residents as a non-restraining device that alerts staff to a resident rising from a bed or chair without assistance...Identify residents at risk for falls using fall risk assessment on admission. High risk for falls include but are not limited to frequent falls, confused residents, noncompliant residents, unsteady or weak in ambulating and/or bed rail climber...Notify physician and obtain order for alarm use...."</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p>			

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	<p>Based on observation, interview and record review, the facility failed to ensure the foley catheter tubing was kept from laying on the floor for 1 of 14 residents identified with a foley catheter. (Resident #130)</p> <p>Findings include:</p> <p>Observations of the foley catheter tubing for Resident #130 were as follows:</p> <p>-On 8-12-2014 at 10:50 a.m., the foley catheter tubing was on the floor under the wheelchair as Resident #130 propelled down the C wing hall.</p> <p>-On 8-12-2014 from 11:15 a.m. to 11:50 a.m., during lunch in the Forest Cafe, the foley catheter tubing was laying on the floor under Resident #130's wheelchair.</p> <p>-On 8-13-2014 at 8:16 a.m., during breakfast in the Forest Cafe, the foley catheter tubing for Resident #130 was laying on the floor under the wheelchair.</p> <p>On 8-13-2014 at 9:38 a.m., during an activity in the Forest Care, the foley catheter tubing for Resident #130 remained on the floor under the wheelchair.</p> <p>On 8-13-2014 at 9:55 a.m., an</p>	F000315	<p>F315 It is the policy of this provider to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition indicates a need for same and that a resident who is incontinent receives treatment and services necessary to prevent UTI's, infections and service to restore as much normal bladder function as possible. <u>What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> Upon notification by the surveyor that she had observed the tubing to be on the floor, Resident # 130's catheter tubing was repositioned off the floor. It is worthy to note that the care plan for this resident did indicate that he was prone to fidget with the tubing, which is known to staff to cause it to touch the floor. <u>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Residents with the propensity to be affected by the alleged deficient practice would be identified as those with indwelling catheters. None of the 4 so identified were observed to have the catheter tubing on the floor. <u>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice</u></p>	09/04/2014			

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	<p>observation of Resident #130 in an activity in the Forest Cafe with the Director of Nursing (DON) indicated the foley catheter tubing was laying on the floor.</p> <p>An interview with the DON on 8-13-2014 at 9:58 a.m., indicated the resident preferred the foley catheter tubing to come out of the pant leg and it was difficult to keep the tubing off the floor. The DON indicated the tubing needed to be up off the floor.</p> <p>An interview with CNA #9 on 8-13-2014 at 11:50 a.m., indicated a resident with a foley catheter would have the drain bag placed in a bag and secured under the wheelchair, the tubing would be placed so it comes out the bottom of the pant leg and the tubing should not be on the floor.</p> <p>The record review for Resident #130 began on 8-13-2014 at 3:08 p.m. The physician's recapitulation for June 2014 was signed by the physician on 6-26-2014. Diagnoses included but were not limited to, genitourinary infection, symptomatic prostatic hypertrophy, obstructive uropathy, Alzheimer's disease and depression. The physician orders indicated sulfamethoxazole 400 mg (milligrams)-trimethoprim 8 mg tablet was to be given at bedtime for a chronic</p>		<p><u>does not recur?</u> The Director, Nursing Services/Designee will ensure that each such resident is monitored daily on all shifts Monday through Friday, for two weeks initially and once weekly on 3 shifts thereafter for 6 months to ensure that the resident's catheter tubing is not touching the floor. A summary report will be forwarded for inclusion in the monthly QAA/PI meeting. The QAA/PI Committee will review the summary from above and make recommendations to the Director of Nursing based on the summaries for continued monitoring going forward past 6 months. <u>How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> The Director, Nursing Services/Designee will conduct an audit daily Monday through Friday all 3 shifts, for 2 weeks, then weekly thereafter for 6 months. The results of the audits will be acted on appropriately and then communicated to the QAPI committee at its regularly scheduled meeting. The committee will review, recommend and determine the frequency of continued monitoring as it sees fit. EDC: 09/04/2014</p>				

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F000323 SS=G	<p>urinary tract infection.</p> <p>A review of the infection report dated 8-29-2013 and provided by the DON on 8-13-2014 at 11:50 a.m., indicated the resident had a urinary tract infection due to Enterococcus faecalis (a bacteria). Resident #130 was transferred to the Emergency Room for increased pain and confusion and returned to the facility for intravenous antibiotic.</p> <p>A review of the urinary catheter care plan initiated on 7-5-2013 indicated "...do not let drainage bag or tubing touch the ground at any time...."</p> <p>A "Foley Catheter - Care of Indwelling Catheter" policy dated 7-13-2001 and provided by the DON on 8-13-2014 at 10:50 a.m., indicated "...catheter tubing... should not be touching the floor when resident is sitting in a chair...."</p> <p>3.1-41(a)(1)</p>						
	483.25(h) FREE OF ACCIDENT						

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	<p>HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review the facility failed to ensure a bed alarm was in place and adequate staff were in place for 2 residents (Resident #105 and Resident #117) to prevent falls. This deficient practice resulted in a skin tear for Resident #117 and a fall with a fracture and resultant surgery for Resident #105.</p> <p>The facility also failed to ensure loose pills and alcohol prep pads were not accessible to the 15 of 120 residents in the facility identified as being confused and independently mobile.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #105 on 8/11/14 at 11:21 a.m., indicated the following: diagnoses included, but were not limited to, lung cancer with brain metastasis, frequent falls, hypertension, PVD (peripheral vascular disease), chronic pain, organic insomnia, macular degeneration of retina, depressive disorder, and dementia with behavioral disturbances.</p>	F000323	<p>F 323</p> <p>It is the policy of this provider to ensure the residents' environment remains free of hazards and each resident receives adequate supervision and assistance to prevent accidents.</p> <p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u></p> <p>Resident # 105 had the use of alarms discontinued.</p> <p>Resident #117 has adequate staff for assistance.</p> <p>No other residents were described for the following response - Once discovered, pills and alcohol preps were removed and disposed of accordingly.</p>	09/04/2014			

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	<p>Resident#105 was admitted to the facility on 8/24/13.</p> <p>A Physician's order for Resident #105, dated 9/4/13, indicated Physical Therapy 1-2 weeks for therapeutic exercises, therapeutic activities, gait, neuro re-education, and safety education.</p> <p>A Physician's order for Resident #105, dated 9/11/13, indicated to discontinue physical therapy services after treatment on this date. The order recommended for the resident to continue with restorative programs.</p> <p>A Fall Risk Assessment for Resident #105, dated 10/16/13, indicated the following: he experienced 1-2 falls during the last 90 days, he displayed any of the behaviors (such as easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, periods of lethargy, mental function varies over the course of the day, wanders, abusive, resists care); his balance was unsteady, but he was able to re-balance without physical support; and he currently took or had taken 3 or more medications within the last 7 days (such as anesthetic, antianxiety, anticonvulsant, antidepressant, antihistamine, antihypertensive, antipsychotic,</p>		<p><u>2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u></p> <p>Other residents with the propensity to be affected would be identified as those with a fall risk score of >10 and a bed alarm order. All those so identified have been reassessed.</p> <p>Other residents with the propensity to be affected would be identified as those with 1 to 2 assist care guides. All those so identified have been reassessed.</p> <p><u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u></p> <p>All residents with an order for a Posey alarm will be monitored for alarm placement. The alarm is an optional assistive device no different from a wheelchair or a walker. The alarm only alerts the staff that the transfer may have occurred and neither prevents nor contributes to the fall.</p>				

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	<p>benzodiazepine, cardiovascular, cathartic, hypoglycemic, hypnotic/sedative, muscle relaxant, narcotic). The assessment also indicated a score of 10 which placed him at high risk for falls.</p> <p>A Fall Investigation for Resident #105, dated 10/17/13, indicated he was observed on the floor of his room by staff performing bed check. The investigation also indicated he was wearing only socks and slipped and fell when trying to take himself to the bathroom. The investigation further indicated his care plan was updated with the intervention to reinforce the resident to use his call light for assistance. No injuries were noted from the fall.</p> <p>A physician's order for Resident #105, dated 11/13/13, indicated may have low bed for safety (bed in low position when in bed).</p> <p>A Fall Risk Assessment for Resident #105, dated 11/13/14, indicated the following: he experienced 1-2 falls during the last 90 days; he displayed any of the behaviors; he had moderately impaired vision; he ambulated with problems and with devices; he was not able to attempt the balance test without physical help; he had 1-2 health conditions present (such as</p>		<p>All residents with a care guide direction for 1 to 2 assist have had the care guide revised to read "...2 (two) staff."</p> <p>The all medicine carts are cleaned each night and meticulously searched for residual pills which may have fallen from their container.</p> <p>The Director, Nursing Services/Designee will ensure that each such resident is monitored daily on all shifts Monday through Friday, for two weeks initially and once weekly on 3 shifts thereafter for 6 months to ensure that the alarms are in place; weekly for 6 months to assure the care guides are accurate; once daily for 2 weeks, then once weekly for 6 months to assure there are no loose pills. A summary report will be forwarded for inclusion in the monthly QAA/PI meeting. The QAA/PI Committee will review the summary from above and make recommendations to the Director of Nursing based on the summaries for continued monitoring going forward past 6 months.</p> <p><u>4. How will the provider monitor the systemic changes to ensure</u></p>				

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	<p>cardiovascular, neuromuscular, orthopaedic, electrolyte imbalance, unstable blood sugar, perceptual, psychiatric or cognitive, nutritional factors); and he had currently took or had taken within the last 7 days 3 or more medications. The assessment also indicated a score of 24 which placed him at high risk for falls.</p> <p>A Fall Investigation for Resident #105, dated 11/14/13, indicated he had taken himself to the bathroom, removed his brief, walked back to bed, urinated on the floor, slipped in the urine and fell. The investigation also indicated his care plan was updated with the intervention for bed to be in low position when resident was in the bed. No injuries were noted from the fall.</p> <p>A Minimum Data Set (MDS) assessment for Resident #105, dated 11/25/13, indicated a score of 11 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The MDS also indicated he required extensive assistance with the physical assistance of 1 person for transfers and walking in room. The MDS further indicated he was not steady, only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around,</p>		<p><u>that the alleged deficient practice does not recur?</u></p> <p>The results will be brought to the QAPI committee meetings as scheduled. The committee will make recommendations as it sees fit.</p> <p>EDC – 09/04/2014</p>				

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	<p>moving on and off toilet, and surface-to-surface transfer. The MDS also indicated a walker and wheelchair were normally used by Resident #105.</p> <p>A Fall Investigation for Resident #105, dated 12/4/13, indicated a housekeeper was walking in the hallway and observed the resident on the floor in his room close to the bed of his roommate. The investigation also indicated his care plan was updated with the interventions for a Posey alarm to be used when in bed or up in a chair. No injuries were noted from the fall.</p> <p>A Physician's order for Resident #105, dated 12/4/13, indicated a Posey alarm on when in bed and chair to alert staff of independent transfers (frequent falls).</p> <p>A Fall Risk Assessment for Resident #105, dated 12/7/13, indicated the following: he experienced 3 or more falls during the last 90 days; his cognitive status had changed in the last 90 days; he displayed any of the behaviors; he required assistance with elimination; he displayed an unsteady balance, but was able to rebalance without physical support; he had 1-2 health conditions present; and he had currently took or had taken within the last 7 days 3 or more medications. The Fall Risk Assessment</p>			

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	<p>indicated a total score of 17 which placed Resident #105 at high risk for falls.</p> <p>A Nursing Progress Note for Resident #105, dated 12/8/13 at 7:02 a.m., indicated he sustained a fall at 4:45 a.m. The note also indicated he was found lying on his left side with a walker clenched at both sides. Resident #105 appeared to be alert and oriented times three. The note further indicated the left foot was rotated to the side with pain on movement of the left leg and severe pain on standing up. The note also indicated the physician was called and an order was received to send him to the hospital for evaluation, possible admit, and treatment.</p> <p>A Nursing Note for Resident #105, dated 12/8/13 at 7:33 a.m., indicated his roommate went outside of his room and told staff members "we got a man down in here." The note also indicated the resident was found lying on his left side with his walker turned over at his doorframe of the bathroom. The note further indicated upon assessment his left foot was slightly rotated to the left side. The note also indicated the hip felt in place but the resident had severe pain on little movement of the left leg with a rotated foot, and severe pain as he was briefly placed in a standing position. His physician was notified and an order was</p>			

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	<p>received to send the resident to the ER (Emergency Room). The note also indicated "It was then reported to writer that (resident's name's) posey alarm was hooked up to his recliner but not his actual bed from which he was transferring self to restroom from."</p> <p>A physician's order for Resident #105, dated 12/8/13, indicated to send to ER for evaluation, treatment, and possible admission (fall, possible broken hip).</p> <p>A Nursing Progress Note for Resident #105, dated 12/8/13 at 7:52 a.m., indicated the hospital ER was called and the facility was informed the resident did indeed suffer a broken left hip. The note also indicated he would be admitted to the hospital.</p> <p>An Emergency Room Report for Resident #105, dated 12/8/13, indicated he was brought to the ER with the chief complaint of left hip pain from a fall. The report also indicated the radiographs of the left hip showed a complete displaced angulated left femoral neck fracture. The report further indicated Resident #105 was admitted to the hospital for surgery.</p> <p>A Fall Investigation for Resident #105, dated 12/10/13, indicated his roommate</p>			

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	<p>was asking for assistance when the Certified Nursing Assistant (CNA) entered the room and observed the resident on the floor. The investigation also indicated the nurse entered the room and observed the resident lying on his left side on the floor in the bathroom. The investigation further indicated the resident complained of pain in his left hip and leg region. Orders were given to send the resident to the hospital ER for evaluation. The investigation also indicated the nurse was interviewed and stated "I checked the alarm once the resident was transferred to the hospital and observed the posey box alarmed to the chair pad and not the pad in his bed." The investigation did not indicate if his bed was in the low position.</p> <p>The DON was interviewed on 8/12/14 at 2:42 p.m. During the interview she indicated the Posey alarm should have been on his bed.</p> <p>A Restorative Program for Resident #105, dated 12/26/13, indicated he required 2 assist with all mobility, one following with a wheelchair and one with a contact guard assist.</p> <p>Review of the Fall Investigations for Resident #105 ,dated 12/20/13 and 12/31/13, indicated he experienced two</p>				

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	<p>falls. Following the fall on 12/31/14, he complained of pain to his right hip and an order was received to send him to the ER for evaluation. Upon his return to the facility a bruise, measuring 14 cm x 6.8 cm was noted to the top of his right foot.</p> <p>A physician's order for Resident #105, dated 12/31/13, indicated strict fall precautions. The order also indicated the resident has fallen within the last month with a hip fracture. The further indicated he was clearly unsafe on his own and required assistance at all times.</p> <p>Review of the Fall Investigations for Resident #105 dated 1/2/14, 1/10/14, 1/15/14, and 1/20/14, indicated he experienced 5 falls with 2 falls occurring on 1/2/14.</p> <p>A Nursing Progress Note for Resident #105, dated 1/2/14 at 1:22 p.m. as a late entry for 1/2/14 at 9:30 a.m., indicated he was ambulating with assist for restorative program and his knee buckled and he fell to the floor, hitting his temple area on the handrails in the hall. The note also indicated a 4.0 cm x 0.4 cm abrasion was noted to his left temple area and an abrasion was noted to his left knee, measuring 1.0 cm x 1.0 cm. The note did not indicate the number of staff assisting him with ambulation or a gait belt or</p>			

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	<p>walker were in use. This was the second fall for Resident #105 on 1/2/14.</p> <p>A staff statement concerning the fall for Resident #105 on 1/2/14 at 1:22 p.m., provided by the DON on 8/14/14 at 9:52 a.m., indicated 2 staff were with him when he was ambulating in the hallway and a gait belt was used. The statement did not indicate whether 1 staff was following behind him with a wheelchair.</p> <p>A Fall Investigation for Resident #105, dated 1/3/14, indicated the resident was ambulating in the hallway with 2 staff members when his knees buckled causing him to fall to the floor. The resident fell left, falling into the wall and handrail, hitting the left temporal area of his head on the handrail as he fell to the floor. The CNA's attempted to slow and cushion the fall. An abrasion was noted to his left temple area and his left knee. Therapy was notified due to second fall of the day. Therapy completed an evaluation to use a saddle cushion with a lap tray. The care plan was updated with the interventions. The investigation did not indicate if a gait belt or walker were in use.</p> <p>The MDS assessment for Resident #105, dated 1/17/14, indicated he required extensive assistance with the physical</p>			

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	<p>assistance of 2 persons for transfers and walking in room. The MDS also indicated he was not steady, only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around, moving on and off toilet, and surface-to-surface transfer.</p> <p>A physician's order for Resident #105, dated 1/29/14, indicated 2 assist with all transfers.</p> <p>Occupational Therapist #20 was interviewed on 8/12/14 at 2:40 p.m. During the interview she indicated the restorative program for Resident #105 was written at the time of his discharge from therapy. She also indicated the restorative program was provided to nursing for staff to follow and a hard copy was in his clinical record.</p> <p>A physician's order for Resident #105, dated 4/15/14, indicated Posey alarm on when in bed or Broda chair to alert staff of attempt to self transfer.</p> <p>A physician's order for Resident #105, dated 6/13/14, indicated to discontinue the Posey alarm in bed and to discontinue the floor mat at bedside. The order also indicated Posey alarm on when in chair/Broda to alert staff of attempts at</p>			

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	<p>self transfer.</p> <p>A physician's order for Resident #105, dated 6/20/14, indicated to discontinue Posey alarm in bed.</p> <p>A Nursing Progress Note for Resident #105, dated 7/22/14, indicated he was observed on the right side of his bed on the floor. The note also indicated he had rolled off the bed and onto the floor. The note further indicated his bed was in the low position at the time. A small skin tear was noted to his right outer calf.</p> <p>A Fall Risk Assessment for Resident #105, dated 7/22/14, indicated he experienced 1-2 falls during the last 90 days; displayed behaviors such as easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, periods of lethargy, mental function varies over the course of the day, wanders, abusive, resists care; elimination with assistance; confined to chair; not able to attempt balance test without physical help; 3 or more health conditions present; and medications. The assessment also indicated he was at high risk for falls and the intervention of a sensory pad to his bed was initiated.</p> <p>Review of the Fall Investigation for</p>			

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	<p>Resident #105, dated 7/23/14, indicated he was observed laying on the floor in his room beside his bed on his back. The investigation also indicated the Posey alarm which had been used in his Broda chair and bed were discontinued on 6/26/14 due to resident's decreased responsiveness</p> <p>A facility care plan for Resident #105, with a start date of 8/24/13 and the most current review date of 7/23/14, indicated the problem area of potential for falls related to confusion, often doesn't use call light, weakness, and history of falls. Approaches to the problem included, but were not limited to, anticipate and meet needs as resident often does not use call light to request assist, be sure call light is in reach and encourage resident to use it for assistance as needed, respond promptly to requests for assistance, encourage use of assistive device of walker, encourage to wear non-skid footwear when transferring or up in wheelchair, floors free from spills or clutter, provide adequate glare free lighting, personal items within reach, reinforce resident to use call light to call for assistance periodically, and monitor for changes in balance, gait, or ability transfer/ambulate safely. The intervention of place bed in low position when in bed was added on 11/15/13. The</p>			

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	<p>intervention of Posey alarm to be in place when in bed and/or chair was added on 12/4/13.</p> <p>2. Review of the clinical record for Resident #117 on 8/12/14 at 1:54 p.m., indicated the following: diagnoses included, but were not limited to, hemiplegia (paralysis), PVD (peripheral vascular disease), anemia, and hypertension.</p> <p>A Minimum Data Set (MDS) assessment for Resident #117, dated 6/30/14, indicated he required extensive assistance with the physical assistance of 2 staff for transfers. The MDS also indicated he was not steady, only able to stabilize with staff assistance.</p> <p>A Fall Risk Assessment for Resident #117, dated 6/27/14, indicated: he displayed any of the behaviors of easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, periods of lethargy, mental function varies over the course of the day, wanders, abusive, resists care; he required assistance with elimination; he was confined to a chair; he was not able to attempt balance test without physical help; he had 3 or more health conditions present (such as cardiovascular,</p>			

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	<p>neuromuscular, orthopaedic, electrolyte, perceptual, psychiatric or cognitive, nutritional factors); and he had currently taken or taken within the last 7 days 3 or more medications (such as anesthetic, antianxiety, anticonvulsant, antidepressant, antihistamine, antihypertensive, antipsychotic, benzodiazepine, cardiovascular, cathartic, hypoglycemic, hypnotic/sedative, muscle relaxant, narcotic). The assessment also indicated a total score of 20, which placed him at high risk for falls.</p> <p>Nursing Progress Notes for Resident #117, dated 8/7/14 at 7:32 a.m., indicated a CNA was transferring him from his bed to his wheelchair when his foot slid from under him and he was lowered to the floor. The note also indicated he received a skin tear to his right calf. The note further indicated his physician was notified and the order received for Bacitracin (antibiotic ointment) and Band-Aid to skin tear daily.</p> <p>A Skin Assessment Form for Resident #117, dated 8/7/14, indicated a skin tear measuring 1 cm (centimeter) x 5 cm on his right calf. The assessment also indicated the treatment of Bacitracin and cover with a Band-Aid daily.</p> <p>A Resident Care Guide for all shifts,</p>				

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	<p>provided by the Director of Nursing on 8/12/14 at 10:30 a.m., indicated Resident #117 required a gait belt and 1-2 assist for transfers.</p> <p>A facility care plan for Resident #117, with a start date of 4/18/14, indicated the problem area of potential for falls related to hemiparesis, impaired mobility, osteoarthritis, and incontinence. Approaches to the problem included, but were not limited to, anticipate and meet needs, encourage to wear non-skid footwear when transferring or up in wheelchair, floors free from spills or clutter, provide adequate glare free lighting, personal items within reach, and monitor for changes in balance, gait, or ability to transfer safely. The care plan did not indicate the need for a gait belt during transfers or the number of staff required to transfer him safely.</p> <p>RN #18 was interviewed on 8/13/14 at 10:15 a.m. During the interview she indicated the resident care guides were developed by the director of restorative services.</p> <p>RN #19 was interviewed on 8/13/14 at 10:30 a.m. During the interview she indicated she based the resident care guide for 1-2 assist for transfers for Resident #117 on the physician order for</p>			

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	<p>transfer with one assist, with a start date of 1/4/13, and not on the MDS. She also indicated there were no guidelines for staff to follow on when to use 1 person assist and when to use 2 person assist and the physician order for 1 assist for transfer had not been reviewed. She further indicated Resident #117 was to be seen by his physician to address and determine the exact order for his requirements for transfer. The physician's order for one assist for transfers had not been updated since 1/14/13.</p> <p>A current facility policy "Resident Alarms for Safety", revised on May, 2013 and provided by the Staff Development Coordinator on 8/13/14 at 10:15 a.m., indicated "...Resident alarms may be used for residents as a non-restraining device that alerts staff to a resident rising from a bed or chair without assistance...Identify residents at risk for falls using fall risk assessment on admission. High risk for falls include but are not limited to frequent falls, confused residents, noncompliant residents, unsteady or weak in ambulating and/or bed rail climber...Notify physician and obtain order for alarm use...."</p> <p>A current facility policy "Fall Prevention", dated 2/1/94 and provided</p>			

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	<p>by the Director of Nursing on 8/13/14 at 8:30 a.m., indicated "...It is the policy...to identify residents at risk for falls and to implement a fall prevention program to reduce the risk of falls and possible injury... Within three (3) days of admission...complete the initial risk assessment...The charge nurse or the unit manager will reassess each resident...Based on the outcome of the assessments, a fall risk prevention plan will be incorporated into the resident's comprehensive plan of care...All staff involved with the resident's care will be notified on the resident's fall risk status...The interdisciplinary team will review the resident's fall risk prevention plan at a minimum of quarterly, during care conference, and modify the plan as needed, based upon the resident's functional status during the review period. Referrals will be made to other health professionals as needed...High fall risk controls: a) Make frequent checks...d) Provide safety devices...f) Provide assistive devices...If a resident experiences a fall, further investigation and assessment is imperative to reduce the risk of more falls...."</p> <p>A current facility policy "Restorative Program", revised on May, 2013 and provided by the Staff Development Coordinator on 8/13/14 at 19:15 a.m.,</p>			

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	<p>indicated "...Restorative Nursing Programs will be set up under the supervision/recommendations of the therapy department for those residents that require ongoing treatment to maintain or improve their level of independence and range of motion...Documentation of number of aides to assist..."</p> <p>3. An observation of the Peach Tree medication cart on 8-12-2014 at 10:38 a.m., indicated 2 pills (a white capsule and a white tablet) were in the bottom of the side compartment of the medication cart where the straws were located. The side compartment was located just below eye level of a resident in a wheelchair.</p> <p>An interview with Nurse #1 and Nurse #2 on 8-12-2014 at 10:38 a.m., indicated they were not aware of the loose pills in the side compartment.</p> <p>On 8-13-2014 at 8:30 a.m., the Director of Nursing (DON) indicated there were 15 residents in the facility who were confused and independently mobile.</p> <p>A policy "Medication Storage in the Facility" dated January 2007 and provided by the DON on 8-13-2014 at 11:30 a.m., indicated "...the medication supply is accessible only to licensed</p>				

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	<p>nursing personnel..." and "...the provider pharmacy dispenses medications in containers...medications are kept in these containers...."</p> <p>4. An observation of the Maple Street medication cart on 8-12-2014 at 2:11 p.m., indicated an opened box of alcohol prep pads was in the side compartment of the medication cart. The side compartment was located just below eye level of a resident in a wheelchair.</p> <p>An interview with Nurse #4 on 8-12-2014 at 3:20 p.m., indicated the alcohol pads that were stored in the outside compartment of the Maple Street medication cart were not usually there as the box usually contained tape. Nurse #4 counted 19 alcohol pads inside the open box stored in the open side compartment of the medication cart.</p> <p>An interview with the DON on 8-14-2014 at 9:55 a.m., indicated the alcohol prep pads were to be stored inside the locked medication cart and the DON indicated it was not expected for the alcohol prep pads to be stored in the open compartment on the side of the medication cart. The DON indicated the alcohol prep pads should have been stored in the locked medication cart.</p>						

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F000332 SS=E	<p>A copy of the Material Safety Data Sheet for the 70% Isopropyl Alcohol in water dated 10-17-1996 and provided by Nurse #23 indicated for "...emergency and first aid procedures...ingestion-give 1 pint warm water...in all cases seek emergency medical attention immediately...."</p> <p>A review of a copy of the alcohol medium prep pad package identified as "...saturated with 70% alcohol....", used in the facility and provided by the DON on 8-14-2014 at 9:55 a.m., indicated "...Warnings...keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>3.1-45(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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 a medication error rate</p>	F000332	F-332 <u>It is the policy of this provider to ensure medication error rate is less than 5%. <i>What corrective action(s) will be</i></u>	09/04/2014			

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	<p>greater than 5%, with the facility having 5 medication errors out of 28 opportunities for error, resulting in a 17.8% error rate.</p> <p>This affected 5 of 13 residents observed for medication pass (Residents #126, #145, #12, #70 and #50), and 3 of 6 nurses observed to pass medications. (Nurse #1, #3 and #4)</p> <p>Findings include:</p> <p>1. During the medication pass observation, Nurse #4 was observed to administer Resident #126's potassium chloride on 8-11-2014 at 4:26 p.m. without food.</p> <p>A review of the signed Physician's recapitulation (recap) for July 2014 indicated diagnoses included but were not limited to, syncope, weakness, recurrent anemia, Parkinson's disease, hypertension, rheumatoid arthritis and paroxysmal a-fib (atrial fibrillation).</p> <p>A review of the July 2014 recap indicated an order for potassium chloride ER (extended release) 10 MEQ (milli-equivalents), take 2 caps (20 MEQ) by mouth twice daily with food for hypokalemia (low potassium).</p> <p>A review of the Meal Time Schedule</p>		<p><u>accomplished for the resident(s) found to be affected by the alleged deficient practice?</u></p> <p>Resident #126 potassium was administered with food.</p> <p>Resident #145, 12, 70 and 50 have had their physician order for short acting insulin "...administer with 15 gm snack if more than 15 minutes before next meal."</p> <p><u>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u></p> <p>Residents with the propensity to be affected by the alleged deficient practice would be identified as those with orders for potassium chloride or short acting insulin. Residents so identified all had their physician order for short acting insulin revised to read "...administer with 15 gm snack if more than 15 minutes before next meal." Potassium is given with the meal or food as appropriate.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The Director, Nursing Service/designee will review physician orders to ensure all new orders are processed appropriately. All residents receiving short acting insulin have had the order for that medication revised to read "...administer with 15 gm snack if more than 15 minutes before next meal."</p> <p><u>How will the corrective actions be</u></p>				

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	<p>provided by the Certified Dietary Manager on 8-7-2014 at 12:30 p.m., indicated the evening meal was served in the Forest Cafe between 5:00 p.m. and 6:30 p.m.</p> <p>A review of the Mosby's 2014 Nursing Drug Reference book, identified by the Director of Nursing (DON) as the facility reference material for medication information, on 8-13-2014 at 12:05 p.m., indicated for potassium "...administer: po (by mouth) route...with or after meals...."</p> <p>2. During the medication pass observation, Nurse #3 was observed to administer Resident #145's insulin (Novolog 5 units subcutaneously) on 8-11-2014 at 4:51 p.m. in her room. Resident #145 indicated she would have her evening meal in the dining room (Forest Cafe).</p> <p>An observation on 8-11-2014 at 5:22 p.m., indicated Resident #145 was served her evening meal.</p> <p>A review of the signed Physician's recapitulation (recap) for July 2014 indicated Resident #145's diagnoses included but were not limited to, dementia with behavioral disturbances, diabetes, osteoarthritis, hypertension and diabetic macular edema.</p>		<p><u>monitored to ensure that the deficient practice does not recur?</u></p> <p>The Director, Nursing Services/Designee will ensure that each such resident is monitored daily Monday through Friday, for two weeks initially and once weekly thereafter for 6 months to ensure that the resident's receive a 15 gm snack if more than 15 minutes elapses before the next meal. A summary report will be forwarded for inclusion in the monthly QAA/PI meeting. The QAA/PI Committee will review the summary from above and make recommendations to the Director of Nursing based on the summaries for continued monitoring going forward past 6 months. <u>Date of compliance:</u> 09/13/2014 .</p>		

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	<p>A review of the July 2014 recap indicated an order Novolog 5 units sub q (subcutaneously) before meals for diabetes.</p> <p>3. During the medication pass observation, Nurse #1 was observed to administer Resident #12's insulin (Novolog 5 units sub q) for a blood sugar of 154 on 8-12-2014 at 10:55 a.m. in her room.</p> <p>An observation on 8-12-2014 at 11:20 a.m., indicated Resident #12 arrived at the Forest Cafe and was served her lunch at 11:47 a.m. Water and coffee were provided while the resident was waiting for her meal to be served.</p> <p>A review of the signed Resident's Diagnosis list dated 7-24-2014 indicated Resident #12's diagnoses included but were not limited to, diabetes, chronic obstructive pulmonary disease, hypertension, congestive heart failure, chronic kidney disease, hemiplegia affecting the dominant side due to cerebrovascular disease and difficulty in walking.</p> <p>A review of the signed Physician's admission orders dated 7-16-2014 indicated an order for Novolog 5 units</p>			

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	<p>sub q before meals for diabetes.</p> <p>4. During the medication pass observation, Nurse #1 was observed to administer Resident #70's insulin (Novolog 4 units sub q) for a blood sugar of 242 on 8-12-2014 at 11:04 a.m. in her room.</p> <p>An observation on 8-12-2014 at 11:20 a.m., indicated Resident #70 was in the Forest Cafe dining room and her lunch was served at 11:35 a.m.</p> <p>A review of the signed Physician's recapitulation (recap) for July 2014 indicated Resident #70's diagnoses included but were not limited to, diabetes, hypertension, atrial fibrillation, anemia, osteoporosis, Parkinson's disease, depression and weight loss.</p> <p>A review of the July 2014 recap indicated the order for Novolog was to inject sub q per sliding scale. The sliding scale was based on a glucose check before meals and at bedtime with a blood sugar of 181 - 250 = 4 units of Novolog would be given; a blood sugar of 251 - 300 = 6 units of Novolog would be given and a blood sugar of 301 - 350 = 8 units of Novolog given.</p> <p>5. During the medication pass</p>				

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	<p>observation, Nurse #1 was observed to administer Resident #50's insulin (Novolog 4 units sub q) for a blood sugar of 190 on 8-12-2014 at 11:11 a.m.</p> <p>An observation on 8-12-2014 at 11:34 a.m., indicated Resident #50 arrived in the Forest Cafe and the resident's lunch was not served by 11:50 a.m.</p> <p>A review of the signed Resident's Diagnosis list dated 6-27-2014 indicated Resident #50's diagnoses included but were not limited to, hemiplegia affecting the dominant side due to cerebrovascular disease, lack of coordination, peripheral vascular disease, diabetes, aphasia (difficulty speaking), hypertension, depression and glaucoma.</p> <p>A review of the signed Physician's admission orders dated 6-20-2014 indicated Insulin aspart (Novolog) was to be injected sub q per sliding scale. The sliding scale was based on a glucose check before meals and at bedtime with a blood sugar of 181 - 250 = 4 units of Novolog would be given; a blood sugar of 251 - 300 = 6 units of Novolog would be given and a blood sugar of 301 - 350 = 8 units of Novolog given.</p> <p>A review of the meal time schedule provided by the Dietary Manager on</p>			

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	<p>8-7-2014 at 12:30 p.m., indicated the lunch meal began in the Forest Cafe (main dining room for A and C wings) and was scheduled from 11:00 a.m. to 1:00 p.m.</p> <p>An interview with Nurse #2 on 8-13-2014 at 9:17 a.m., indicated for residents with Novolog insulin injections, meals should be served within 15 minutes after the insulin injections were given.</p> <p>An interview with the Pharmacist #8 on 8-13-2014 at 9:21 a.m., indicated residents who were given Novolog insulin injections should have a meal or snack within 15 minutes of the injection.</p> <p>An interview with the DON (Director of Nursing) on 8-13-2014 at 10:05 a.m., indicated for residents with Novolog insulin injections, a meal should be served within 30 minutes of the injection.</p> <p>A review of the Mosby's 2014 Nursing Drug Reference book on 8-13-2014 at 12:05 p.m., indicated the Novolog (Insulin aspart) was a "high alert..." medication, "...is given...just before the beginning of a meal..." and the onset was "...10-20 minutes..."</p> <p>3.1-25(b)(9)</p>			

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to ensure staff washed and/or sanitized their hands at the appropriate time during meal service and failed to protect resident meal trays and food from potential contamination during meal service potentially affecting 28 residents out of 119 residents who ate their meals in the Tea Dining Room and the Java Dining Room.</p> <p>Findings include:</p> <p>1. During an observation of the breakfast meal in the Tea Dining Room on 8/8/14 the following was observed:</p> <p>- At 7:42 a.m., Certified Nursing Assistant (CNA) #10 was observed to remove a meal tray from an open cart containing meal trays and place it on the half-wall separating the dining room and the common hallway. She was not</p>	F000371	<p>It is the policy of this provider to store, prepare, distribute and serve food under sanitary conditions.</p> <p><u>What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u></p> <p>No residents were noted by the surveyors to have been affected by this alleged deficient practice. Staff were instructed to wash their hands between trays and to deliver only covered trays to the residents.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u></p>	09/04/2014			

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	<p>observed to wash or sanitize her hands before removing the meal tray from the cart. She removed all the lids from the glasses and mugs and removed the protective dome cover from the plate to prepare the plate for the resident. She then carried the un-protected meal tray from the half-wall through the common hallway and around the open cart before delivering the meal tray to the resident.</p> <p>- At 7:44 a.m., CNA #10 was observed to remove another meal tray from the open cart and place it on the half-wall separating the dining room and the common hallway. She was not observed to wash or sanitize her hands before removing the meal tray from the cart. She removed all the lids from the glasses and was observed to handle a glass by the drinking rim when pouring out the ice water and pouring juice into the glass. She was observed to also remove the protective dome cover from the plate to prepare the plate for the resident. She then carried the un-protected meal tray from the half-wall through the common hallway and around the open cart before delivering the meal tray to the resident.</p> <p>- At 7:47 a.m., CNA #10 was observed to push a resident up closer to the table by moving her geri-chair. She then was observed to remove another meal tray</p>		<p>Residents with the propensity to be affected by the alleged deficient practice would be identified as those receiving trays on the wings (units).</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u></p> <p>The Nursing staff received education to the importance of hand hygiene between resident trays and delivering the trays to the resident covered.</p> <p><u>How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u></p> <p>A hand hygiene audit was developed to monitor each meal. Audits will be conducted daily for 2 weeks, weekly thereafter for 6 months. These audits will be submitted to the QAA/PI (Performance Improvement) committee for review and recommendation concerning compliance. The committee will determine the need for continued</p>				

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	<p>from the open cart and place it on the half-wall separating the dining room and the common hallway. She was not observed to wash or sanitize her hands after assisting a resident in their geri-chair and before handling the meal tray from the open cart. She was observed to handle 3 disposable glasses by the drinking rims while pouring beverages into the glasses. She then handled the glasses by the drinking rims when placing the full glasses of beverages on the meal tray. She was observed to also remove the protective dome cover from the plate to prepare the plate for the resident. She then carried the un-protected meal tray from the half-wall through the common hallway and around the open cart before delivering the meal tray to the resident.</p> <p>- At 7:51 a.m., CNA #11 was observed to push a resident in a wheelchair down the hallway into the dining room. She immediately removed a meal tray from the open cart and passed it to a resident without washing or sanitizing her hands.</p> <p>2. During an observation of the breakfast meal in the Java Dining Room on 8/8/14 the following was observed:</p> <p>- At 8:14 a.m., CNA #12 was observed to push an open cart containing meal trays</p>		<p>monitoring as it sees fit.</p> <p>EDC: 09/04/2014</p>		

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	<p>down the hallway and placed it by the entrance into the dining room. She then removed a meal tray from the open cart and delivered it to a resident's room. She was not observed to wash or sanitize her hands before delivering the meal tray.</p> <p>- At 8:17 a.m., CNA #12 removed a second meal tray from the open cart and delivered it to a resident's room. She was not observed to wash or sanitize her hands before handling the meal tray.</p> <p>- At 8:19 a.m., CNA #13 was observed to place a pen in the pocket of her uniform and immediately removed a meal tray from the open cart and delivered the meal tray to a resident in the dining room. She was not observed to wash or sanitize her hands before handling the meal tray.</p> <p>3. During an observation of the lunch meal in the Tea Dining Room on 8/8/14 the following was observed:</p> <p>- At 11:34 a.m., LPN #14 was observed to remove a meal tray from the open cart and deliver it to a resident's room. She was not observed to wash or sanitize her hands before delivering the meal tray.</p> <p>- At 11:36 a.m., CNA #15 was observed to remove meals trays and deliver them to 2 residents in the dining room. She was</p>			

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	<p>not observed to wash or sanitize her hands before handling the meals trays.</p> <p>- At 11:39 a.m., CNA #15 was observed to move a resident in a wheelchair up closer to the dining table. She then used the resident's eating utensils to cut up her food. She also was observed to remove a slice of bread from the wrapper with her bare fingers, place the slice of bread on the meal tray, and use her bare fingers to stabilize the bread while she applied butter. She was not observed to wash or sanitize her hands after touching the wheelchair.</p> <p>- At 11:40 a.m., CNA #10 was observed to reposition a resident in her geri-chair. She then removed a meal tray from the open cart and delivered it to the resident. She was not observed to wash or sanitize her hands before handling the meal tray.</p> <p>- At 11:45 a.m., CNA #16 was observed to move a resident in the dining room. She then picked up the resident's eating utensils and placed the eating utensils into the hand of the resident. She was not observed to wash or sanitize her hands before picking up the eating utensils.</p> <p>4. During an observation of the lunch meal in the Tea Dining Room on 8/12/14</p>			

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	<p>the following was observed:</p> <ul style="list-style-type: none"> - At 11:31 a.m., CNA #16 was observed to touch her uniform and the gait belt fastened around her waist. She then removed a meal tray from the open cart and delivered it to a resident in the dining room. She was not observed to wash or sanitize her hands before handling a meal tray. - At 11:34 a.m., CNA #16 was observed to remove another meal tray from the open cart and delivered it to a resident in the dining room. She was not observed to wash or sanitize her hands. <p>5. During an observation of the lunch meal in the Java Dining Room on 8/12/14 the following was observed:</p> <ul style="list-style-type: none"> - At 11:45 a.m., CNA #17 was observed was observed to take a meal tray from the open cart containing meal trays and place it on the half-wall separating the dining room and the common hallway. She was not observed to wash or sanitize her hands before removing the meal tray from the cart. She removed all the lids from the glasses and mugs and removed the protective dome cover from the plate to prepare the plate for the resident. She then carried the un-protected meal tray from the half-wall through the common 						

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	<p>hallway and around the open cart before delivering the meal tray to the resident.</p> <p>The Dietary Manager and the Clinical Manager were interviewed on 8/12/14 at 2:16 p.m. During the interview they indicated they would expect staff to wash their hands before meal service started and to use hand sanitizer in-between the passing of meal trays. They also indicated staff should wash their hands after touching anything soiled. They further indicated staff should never touch food with their bare hands and should take meal trays to residents completely covered.</p> <p>A current facility policy "Meal Service", revised on June, 2013, and provided by the Clinical Manager on 8/12/14 at 3:56 p.m., indicated "...To insure resident meals are prepared and served in an organized manner and are sanitary and safe to consume...Nursing is responsible for distributing the trays to and from the residents...a. Nursing will perform hand hygiene between each resident when passing meals tray to those eating in their room or in the feeding lounges on each wing or when contaminated...b. Nursing staff will not handle prepared food without proper hand protection or hand hygiene...c. Nursing staff will not uncover food prior to serving tray to the</p>			

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F000431 SS=E	<p>resident..."</p> <p>6. During an observation of lunch meal service to Resident's room on A-Wing on 8/8/14 from 11:28 a.m. to 12:20 p.m. the following was observed:</p> <p>- At 11:50 a.m., Certified Nursing Assistant (CNA) #10 was observed to touch her face and was not observed to wash or sanitize her hands before removing a lunch meal tray from the cart. CNA #10 delivered the tray to an unidentified Resident in their room. The CNA removed the protective dome cover from the plate and the plastic lids from the food and beverages on the tray without performing hand hygiene.</p> <p>3.1-21(i)(1)</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 establishes a system of records of receipt and disposition of all controlled drugs in</p>						

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	<p>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 individual unidentified medication tabs/capsules were secured in the medication container in 4 of 4 medication carts in 2 of 3 wings (Wing A and C). The facility also failed to ensure expired Nepro supplements were removed from 1 of 2 pantries.</p>	F000431	<p>It is the policy of this provider to ensure individual unidentified medication tabs/capsules were secured in a medication container and discard expired materials.</p> <p><u>1. What corrective action(s) will</u></p>	09/04/2014

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	<p>Findings include:</p> <p>An observation of the Elm Street medication cart with Nurse #5 on 8-12-2014 at 2:55 p.m., indicated 5 1/2 pills were loose in the bottom of the second drawer of the medication cart and 2 pills were loose in the bottom of the 3rd drawer.</p> <p>An observation of the A wing supply room with Nurse #5 on 8-12-2014 at 3:05 p.m., indicated nineteen 8 ounce cans of Nepro had an expiration date of 7-1-2014 and one 8 ounce can of Nepro had an expiration date of 5-1-2014.</p> <p>An observation of the Maple Street medication cart with Nurse #4 on 8-12-2014 at 3:10 p.m., indicated 1 loose pill was found in the bottom of the 2nd drawer.</p> <p>An interview with Nurse #4 on 8-12-2014 at 3:20 p.m., indicated she was not sure how often the medication carts were cleaned.</p> <p>An observation of the Peach Tree medication cart with Nurse #6 on 8-12-2014 at 3:25 p.m., indicated there was 1 capsule and a half of a pill found in the bottom of the 3rd drawer.</p>		<p><u>be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u></p> <p>No residents were described as affected - Once discovered, expired material, pills and alcohol preps were removed and disposed of accordingly.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u></p> <p>No residents were described as affected - Once discovered, expired material, pills and alcohol preps were removed and disposed of accordingly.</p> <p><u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u></p> <p>The all medicine carts are</p>				

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	<p>An interview with Nurse #6 on 8-12-2014 at 3:30 p.m., indicated the medication carts were cleaned weekly on the night shift.</p> <p>An observation of the Spring Street medication cart with Nurse #7 on 8-12-2014 at 3:40 p.m., indicated there were a total of 6 pills found in the bottom of the medication cart - 2 pills in the 2nd drawer, 3 pills in the 3rd drawer and 1 pill in the bottom drawer.</p> <p>An interview with the Director of Nursing (DON) on 8-13-2014 at 10:00 a.m., indicated the medication carts were checked every night for expired medications and the staff was also to check the bottom of the drawer for loose pills.</p> <p>An interview with the DON on 8-14-2014 at 8:57 a.m., indicated the unit managers usually check the expiration dates of the supplements during the daily rounds.</p> <p>An interview with Nurse Unit Manager #24 on 8-14-2014 at 9:00 a.m., indicated the Scheduler was responsible for ensuring the expired supplements were removed.</p> <p>An interview with the Scheduler #25 on</p>		<p>cleaned each night and meticulously searched for residual pills which may have fallen from their container.</p> <p><u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u></p> <p>The DNS/designee will monitor by the use of an audit tool weekly for 6 months. The results will be brought to the QAPI committee meetings as scheduled. The committee will make recommendations as it sees fit.</p> <p>EDC – 09/04/2014</p>				

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F000441 SS=D	<p>8-14-2014 at 9:20 a.m., indicated she did the ordering and stocking of the supplements and also would remove any expired supplements and products.</p> <p>A policy "Medication Storage in the Facility" dated January 2007 and provided by the DON on 8-13-2014 at 11:30 a.m., indicated "the provider pharmacy dispenses medications in containers...medications are kept in these containers...."</p> <p>A policy for the removal of expired supplements was requested on 8-14-2014 at 12:15 p.m. but was not provided.</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(o)</p>				
	483.65 INFECTION CONTROL, PREVENT				

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	<p>SPREAD, LINENS</p> <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. Based on observation, interview and record review the facility failed to use personal protective equipment and</p>	F000441	F 441 It is the policy of this provider to maintain standards to prevent the	09/04/2014			

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	<p>adequate hand washing for 1 of 2 Residents who were on isolation precautions for infections residing on the A-wing of the facility. (Resident #117)</p> <p>Findings include:</p> <p>1. On 8/7/14 at 12:05 p.m., during initial tour of the facility, observed CNA (Certified Nurse's Aide) #22 deliver a noon meal tray to Resident #117. A red stop sign on door frame indicated the following, "PRIOR TO ENTERING ROOM PLEASE ASK NURSE ABOUT PRECAUTIONS TO BE USED...STOP...WASH HANDS BEFORE AND AFTER PATIENT CONTACT." CNA #22 entered Resident #117's room without washing her hands, donning disposable gloves and gown or a mask and delivered the meal tray to the over bed table where the resident sat in his wheelchair. CNA #22 removed the protective dome cover from the plate and the plastic lids from the food and beverages on the tray. CNA #22 left the resident's room without washing her hands with soap and water.</p> <p>On 8/13/14 at 2:00 p.m., the clinical record of Resident #117 was reviewed. Diagnoses included, but were not limited to the following: CVA (Cerebrovascular Accident/ a stroke) with right</p>		<p>spread of infections.</p> <p><u>1. What corrective action(s) have been accomplished for the resident(s) found to have been affected by the alleged deficient practice?</u></p> <p>Resident # 117 is no longer on contact precautions.</p> <p><u>2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u></p> <p>Other residents with the propensity to be affected would be identified as those with contact precautions. None were so identified.</p> <p><u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u></p> <p>All staff have been educated on</p>	

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	<p>hemiparesis, aphasia, osteoarthritis of right knee, HTN (hypertension/high blood pressure) and C-Diff (Clostridium Difficile).</p> <p>Review of Resident #117's Physician Orders indicated the following: -On 7/16/14, "...C-Diff (Clostridium Difficile, a bacteria) culture..." -On 7/16/14, "...1) Vancomycin (an antibiotic) 125 mg (milligrams) po (by mouth) QID (four times a day) x (times) 6 days....2.) Re-check stool for C-diff (8/27/14)....3) Contact isolation..." -On 7/22/14, "...Vancomycin 125 mg po QID for additional 10 days, Dx (diagnosis) C-Diff..." -On 7/23/14, "...Vancomycin 125 mg/5 ml (milliliters) po QID x 10 days then TID (three times a day) x 10 days, then BID (two times a day) x 10 days, then DC (discontinue)...DC other Vancomycin orders....)</p> <p>Review of Resident #117's laboratory results dated 7/16/14 indicated the following, "...Clostridium Difficile Toxin NAA (a type of lab test): POSITIVE..." The laboratory report indicated results were called to the facility nurse and a copy was sent to the M.D....."</p> <p>Review of the Resident Care Guide...All Shifts provided by the DON on 8/12/14</p>		<p>correct procedures of contact precautions. The certified NA received re-education on the appropriate PPE for contact isolation.</p> <p><u>4. How will the provider monitor the systemic changes to ensure that the alleged deficient practice does not recur?</u></p> <p>The DNS or designee will monitor by the use of an audit tool weekly for 6 months, if a resident is placed in contact isolation – as none are at this time. The results will be brought to the QAA/PI committee as scheduled. The committee will make recommendations as it sees fit.</p> <p>EDC – 09/04/2014</p>				

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	<p>at 10:30 a.m., indicated Resident #117 was in "Contact Isolation for C-Diff..."</p> <p>2. On 8/13/14 at 12:05 p.m., observed CNA #21 deliver a noon meal tray to Resident #117, who was in contact isolation. Resident #117 was seated in his wheelchair next to his doorway. CNA #21 entered the Resident's room with the meal tray and put it on the over bed table. The CNA did not wash her hands with soap and water and she did not don gloves. She proceeded to push Resident #117 in his wheelchair up to the bedside table and remove the protective dome cover from the plate and the plastic lids from the food and beverages. CNA #21 did not wash her hands or don gloves before removing the covers from the food. The CNA left Resident #117's room without washing her hands with soap and water.</p> <p>An interview with the Infection Control Nurse on 8/14/14 at 10:00 a.m., indicated the staff should at least wear gloves and wash their hand with soap and water when delivering meal trays to Residents in contact isolation. She also indicated staff were to always wash their hands with soap and water before leaving an isolation room.</p>			

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	<p>On 8/14/14 at 11:00 a.m., the facility's Infection Control Nurse provided the Facility's Policy, titled, Transmission Based Precautions, with revised dated of 9/19/13 which included the following, "...Contact Precautions...a) Definition. i) Contact or touch is the most common and most significant way that infectious agents are spread. Contact transmission can occur by touching the patient directly, through contact with the patient's environment, or by using contaminated gloves or equipment...iii) Clostridium difficile Infection (CDI); known or suspected....Personal Protective Equipment (PPE). i) Noted: PPE should be donned before contact with a patient or ANY surface in the patient's surroundings...ii) Clean hands before putting on gloves...iii) Put on gown and gloves before entering patients room...iv) Remove and discard all PPE within the patient's room at the time of exit...v) Clean hands after removing PPE....(1) Use soap and water hand washing upon exiting the room of patients on Contact Precautions for diarrhea illness, unless C. diff can be ruled out...."</p> <p>3.1-18(l)</p>			

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F000520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality			

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	<p>assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility failed to implement an action plan for the identified concerns regarding the handwashing and sanitizing of hands during meal service, ensuring food was protected from potential contamination in the dining rooms; monitoring and providing a meal or snack within the recommended amount of time after administering a fast acting insulin, monitoring a safe environment for residents for fall prevention and for loose pills and alcohol prep pads being accessible in the side compartments of the medication carts, monitoring for</p>	F000520	<p>It is the policy of this provider to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility and at least 3 other members of the facility staff.</p> <p><u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>No residents were identified</p>	09/04/2014			

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	<p>expired supplements and for meal tray delivery to a resident on isolation without using the appropriate personal protective equipment or performing handwashing prior to and after delivery of the tray, monitoring foley catheter care with tubing that was on the floor and maintaining the posting of the ISDH (Indiana State Department of Health) complaint number at a height level that could be read and posting of the complaint number in the intermediate care wings of the facility. This had the potential to affect 120 of 120 residents who resided at the facility.</p> <p>Findings include:</p> <p>The QAPI (Quality Assurance/Performance Improvement) committee, consisted of the Administrator, the DON (Director of Nursing), the Medical Director and the Managers of each of the Facility's Departments. The committee met monthly and they failed to identify and to implement an action plan to correct and monitor the handwashing and sanitizing of hands during meal service, ensuring food was protected from potential contamination in the dining rooms; monitoring and providing a meal or snack within the recommended amount of time after administering a fast acting insulin,</p>		<p><u>How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?</u></p> <p>No residents will be affected. The QAPI committee has met and developed an action plan for the identified concerns. Those actions to mitigate the concerns are the responses listed here on this 2567.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that he deficient practice does not recur?</u></p> <p>The Administrator will attend any subsequent meeting of the committee for the purpose of verifying the meeting and the agenda.</p> <p><u>How will the corrective action be monitored to ensure that the deficient practice will not recur?</u></p>	

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	<p>monitoring a safe environment for residents for fall prevention and for loose pills and alcohol prep pads being accessible in the side compartments of the medication carts, monitoring for expired supplements and for meal tray delivery to a resident on isolation without using the appropriate personal protective equipment or performing handwashing prior to and after delivery of the tray, monitoring foley catheter care with tubing that was on the floor and maintaining the posting of the ISDH (Indiana State Department of Health) complaint number at a height level that could be read and posting of the complaint number in the intermediate care wings of the facility.</p> <p>An interview with the DON (Director of Nursing) on 8-14-2014 at 11:57 a.m., indicated the QAPI Committee met monthly and indicated the Committee was not aware of these concerns.</p> <p>On 8-14-2014 at 2:28 a.m., the DON provided the facility's policy, Performance Improvement dated 5-2010, which indicated "...The Quality Assurance Committee is responsible for identifying and monitoring areas that require preventive and corrective action, particularly issues which negatively affect quality of care and services</p>		<p>Visit audits will continue a minimum of 6 months. At that time the administrator will submit information gathered from the audits to the QAA/PI committee for review during their monthly meeting for recommendations concerning continued monitoring.</p> <p><u>By what date will the systemic changes be completed?</u> 09/04/2014</p>				

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	provided to residents. The Committee also develops and initiates plans of action to correct any identified quality of care problems and evaluates results of corrective actions for implementation of problem resolutions...." 3.1-52(a)(2)				