

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2013
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DR LAFAYETTE, IN 47905
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00135681.</p> <p>Complaint IN00135681 substantiated, federal deficiencies related to the allegation is cited at F465.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00136919.</p> <p>Survey dates: September 23, 24, 25, 26, 27, October 1 & 2, 2013</p> <p>Facility number: 000147 Provider number: 155243 AIM number: 100266900</p> <p>Survey team: Rita Mullen, RN, TC Bobette Messman, RN (September 24, 25, 26, 27, October 1 & 2, 2013) Sandra Nolder, RN</p> <p>Census bed type: SNF/NF: 114 Total: 114</p> <p>Census payor type: Medicare: 7 Medicaid: 84</p>	F000000	<p>November 1, 2013 This Plan of Correction is the center's credible allegation of compliance for the recent survey of October 2, 2013 at Signature Healthcare of Lafayette, IN. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Date of compliance November 2, 2013. Signature Healthcare of Lafayette, IN respectfully requests paper compliance with this Plan of Correction.</p>	

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

TITLE

(X6) DATE

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

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	<p>Other: 23 Total: 114</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley on October 10, 2013.</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review the facility failed to notify residents, resident's family members, or legal representatives of new physician orders for 3 of 20 residents reviewed</p>	F000157	F 157 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #10, 12, and 157 and their families have been notified	11/02/2013			

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	<p>for notification of new physician orders in a sample of 20 residents reviewed. (Resident #10, #12 and #157)</p> <p>Findings include:</p> <p>1. On 9/30/13 at 3:30 P.M., Resident #10's record was reviewed.</p> <p>A 30 day scheduled Minimum Data Set (MDS) assessment dated 8/21/13 indicated the resident's Brief Interview Status (BIMS) was 12 (mildly cognitively impaired).</p> <p>The resident's record indicated that the resident, resident's family member, or legal representative was not notified of these new physician orders.</p> <p>9/20/12 baclofen (muscle relaxer)10 milligrams by mouth three times times 10 days</p> <p>9/22/13 Psychiatric evaluation Urinalysis and culture and sensitivity</p> <p>9/24/13 15 minute check may be discontinued at this time</p> <p>During an interview on 9/25/13 at 12:05 P.M., the resident indicated she had not</p>		<p>of their new orders. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure regarding notification of new orders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. An audit was conducted on orders written from 10/3/2013 for appropriate notification. Orders with missing notification have been corrected. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure regarding notification of new orders. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure regarding notification of new orders. New physician order form implemented with area for notification on physician order. Licensed nurses have were in-serviced on 10/23/2013 by the DON related to new physician order form. Family/resident notification of new orders will be verified daily by the DON and/or designee as part of the morning clinical meeting. This will occur indefinitely as part of the facility protocol. Further education and/or disciplinary action will be provided as needed for any issues noted. How the</p>		

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	<p>been informed about new physician orders.</p> <p>During an interview on 10/1/13 at 5:10 P.M., the Cedarwood Unit Manager indicated she did not find any documentation that showed the resident or her family members were notified of the new physician orders.</p> <p>2. On 9/27/13 at 9:27 A.M., Resident #12's record was reviewed.</p> <p>A quarterly (MDS) assessment dated 7/23/13 indicated the resident's BIMS was 10 (moderately cognitively impaired).</p> <p>The resident's record indicated that the resident, resident's family member, or legal representative was not notified of these new physician orders.</p> <p>7/29/13 Discontinue oxygen 8/04/13 Add macrobid (antibiotic) as allergy had acute renal failure (ARF) last time given 8/16/13 Cleanse wounds with normal saline before treatment 8/19/13 Occupational therapy-patient discontinue from occupational therapy last treatment day 8/19/13</p>		<p>corrective action(s) will be monitored to ensure the deficient practice will not recur. DON and/or designee will review physician orders as outlined above and report findings to Performance Improvement Committee monthly x 6 months for further review and recommendations to ensure ongoing compliance. Date of compliance: 11/2/2013</p>				

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	<p>During an interview on 9/23/13 at 2:12 P.M., the resident indicated she had not been informed about physician orders that had changed.</p> <p>During an interview on 9/27/13 at 10:00 A.M., the Cedarwood Unit Manager indicated she did not find any documentation that showed the resident or her family members were notified of the new physician orders.</p> <p>3. On 9/30/13 at 3:30 P.M., Resident # 157's record was reviewed.</p> <p>A 90 day (MDS) assessment dated 7/31/13 indicated the resident's BIMS was 6 (severely cognitively impaired).</p> <p>The resident's record indicated that the resident, resident's family member, or legal representative was not notified of these new physician orders.</p> <p>9/10/13 Discontinue pulmocort (steroidal inhaler) Discontinue duoneb (Bronchodilator respiratory treatment) everyday at 2 P.M. Add duoneb 0.5/3 milliliters three times a day by nebulizer 9/16/13 albuterol (bronchodilator 2.5</p>			

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	<p>milligrams/3 milliliters three times a day (limit dose) ipratropium (bronchodilator) 0.5 milligrams three times a day (limit dose) by nebulizer</p> <p>During an interview on 9/25/13 at 10:03 A.M., the resident indicated she did not get informed about new physicians orders.</p> <p>During an interview on 10/1/13 at 4:35 P.M., the Director of Nursing (DON) and the Cedarwood Unit Manager indicated they did not find any documentation that showed the resident or her family members were notified of the new physician orders.</p> <p>A facility policy titled "change in a Resident's Condition or Status" was provided by the DON on 10/1/13 at 2:13 P.M. and deemed current.</p> <p>The policy stated, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and /or status (e.g., changes in level of care, billing/payments, resident rights, etc.)...Unless otherwise instructed by the resident, the Nurse</p>			

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	<p>Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when...b. There is a significant change in the resident's physical, mental, or psychosocial status;...Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status."</p> <p>3.1-5(a)(3)</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident's dignity was maintained while the residents were being assisted to eat during a meal for 2 of 14 residents observed being assisted to eat for 1 of 1 meal observations in 1 of 3 dining rooms observed. (Resident #'s 102 and 178)</p> <p>Findings include:</p> <p>On 9/25/13 at 12:30 p.m., the assisted dining room for Birchwood Unit was observed during lunch. CNA #1 was observed feeding/assisting Resident #102 and Resident #178 at one table while standing.</p> <p>On 9/25/13 at 12:35 p.m., during an interview, with Birchwood Unit Manager, while observing assisted/feeding dining room, she indicated CNA #1 should be sitting down while assisting/feeding Resident #102 and Resident #178.</p> <p>A policy titled "Feeding Residents"</p>	F000241	<p>F 241 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? CNA # 1 was educated on 9/25/2013 per Unit Manager on the policy and procedure related to dignity with feeding assistance of residents. Nursing staff was in-serviced on 10/23/2013 by the DON on the policy related to dignity with feeding assistance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. Nursing staff was in-service on 10/23/2013 by the DON on the policy and procedure related to dignity with feeding assistance of residents. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. Nursing staff was in-serviced on 10/23/2013 by the DON on the policy and procedure related to dignity with feeding assistance of residents. DON and/or designee will conduct random observations of assist dining rooms 3 times per week x 4 weeks, weekly x 8</p>	11/02/2013

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	<p>was provided by the Director of Nursing (DoN), on 9/25/13 at 4:35 p.m., and deemed current. The policy indicated : "... 6. Sit in chair to feed the resident "</p> <p>3.1-3(t)</p>		<p>weeks, and then monthly x 3 months to ensure ongoing compliance as demonstrated by staff sitting to assist residents with feeding. Further education and/or disciplinary action will be provided as needed for any issues noted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. DON and/or designee will conduct dining room observations as outlined above and report findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations to ensure continued compliance. Date of compliance: 11/2/13</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview the facility failed to ensure the physician's order was followed for medication administration for 1 of 11 residents observed for medication administration and physician's order for treatment of pressure ulcer for 1 of 1 resident reviewed for a pressure ulcer treatment. (Resident # 20 and # 35)</p> <p>1. On 9/19/13 at 10:24 a.m., Resident # 20 was observed to take 1 puff of medication Advair diskus 250/50 (respiratory medication). No water rinse of mouth was observed after puff.</p> <p>On 9/30/13 at 2:30 p.m., a record review of Resident #20 physician order on 9/19/13 indicated, "...clarification Advair diskus 250/50 give 1 puff by mouth at each a.m. - rinse mouth with H2O[water] after each use...."</p> <p>On 9/30/13 at 2:30 p.m., a record review of Resident #20 new physician</p>	F000282	<p>F 282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 20 has had Advair diskus 250/50 order clarified to "rinse and spit" with water after each use. LPN # 2 was in-serviced on 9/30/2013 related to following physician order, specifically rinsing mouth following advair administration. Licensed nurses were in-serviced on 10/23/2013 by the DON related to following physician order, specifically rinsing mouth following advair administration. The treatment order for resident #35 has been clarified with wound care clinic. Registered Nurse #5 was in-serviced on 10/2/2013 related to following physician order, specifically correct product during dressing change. Licensed nurses were in-serviced on 10/23/2013 by the DON related to following physician order, specifically correct product during dressing change. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. An audit was conducted on 10/4/13 of all</p>	11/02/2013

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	<p>order clarification indicated "Res. [resident] to rinse and spit H2O [water] following use of advair inhaler."</p> <p>On 9/19/13 at 10:30 a.m., during an interview, LPN #2 indicated Resident # 20 was not allowed water.</p> <p>On 9/30/13 at 2:30 p.m., during an interview, LPN #2 and the Birchwood Unit Manager, indicated Resident # 20 should have rinsed mouth with water after medication administration.</p>		<p>current treatment orders to ensure current order is correct and appropriate. An audit was conducted on 10/4/13 of all current Advair discus orders to ensure the order includes to rinse mouth after administration. License nurses were in-serviced on 10/23/2013 by the DON related to following physician orders. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. Licensed nurses were in-serviced on 10/23/2013 by the DON regarding following physician orders. SDC and/or designee will complete medication administration observations on each nurse by 11/2/2013 to ensure compliance. The SDC and/or designee will complete medication administration observations two times per week for 30 days, then monthly x 5 months. Further education and/or disciplinary action to be provided as needed for any issues noted. SDC and/or designee will complete dressing change observations on each nurse by 11/2/2013 to ensure compliance. The SDC and/or designee will complete random dressing change observations 2 x per week for 30 days, then monthly x 5 months. Further education and/or disciplinary action to be provided as needed for any issues noted. How the corrective action(s) will be</p>	

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	<p>2. The record for Resident #35 was reviewed on 9/30/13 at 11:12 A.M. Diagnoses included, but were not limited to quadriplegia at C5, chronic spasticity, pressure ulcer to buttock, pressure to ankle, general muscle weakness, chronic osteomyelitis pelvic region and thigh, and personal history of noncompliance with medical treatment, presenting hazards to health.</p> <p>The resident went to the wound center for evaluation and treatment of his pressure ulcer wound, which was staged at the wound center as a Stage 4 (pressure ulcer went to bone or covered with black or yellow tissue) on 9/24/13.</p> <p>On 10/2/13 at 11:03 A.M., the Cedarwood Unit Manager provided the physicans order for the left ischial pressure ulcer treatment that stated,</p>		<p>monitored to ensure the deficient practice will not recur. SDC and/or designee will conduct medication administration observations and treatment competencies as outlined above and report findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations to ensure continued compliance. Date of compliance: 11/2/2013</p>		

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	<p>"Left thigh skin care-cleanse area w [sign for with]/NS [normal saline] then apply silver alginate rope [antimicrobial dressing] pack loosley into undermining located at 10-1 oclock change dressing daily and PRN [as needed] cover w/ABD [abdominal] pad"</p> <p>During an observation on 10/2/13 at 9:50 A.M., RN #5 (Registered Nurse) changed the dressing to the resident's left ischium (buttocks) pressure ulcer. After she removed the old dressing, she cleansed the area with 4 x 4 square guaze dressings and a normal saline bullet. She packed the ishcial wound with silver alginate rope dressing with a sterile Q-tip. She applied Exu-dry dressing with a guaze square dressing over the wound and secured it with cover all tape.</p> <p>During an interview on 10/2/13 at 10:23 A.M., RN #5 indicated the Exu-dry dressing was sent from the wound center for the staff to use on the resident's ischium wound to absorp the drainage from the wound.</p> <p>During an interview on 10/2/13 at 11:05 A.M., the Cedarwood Unit Manager indicated there was no order for the Exu-dry dressing and the staff should have called the wound center</p>						

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	<p>and clarified the order when the wound center sent the dressing over to use on the wound.</p> <p>On 10/2/13 at 11:16 A.M., the Director of Nursing provided the policy titled "Dressings, Dry/Clean".</p> <p>The policy stated, "The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. 1. Verify that there is a physician's order for this procedure. (Note: This may be generated from a facility protocol.)... 3. Check the treatment record...."</p> <p>3.1-35(g)(2)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review the facility failed to prevent the possibility of infections for pressure ulcers for 1 of 1 resident observed for dressing changes of pressure ulcers. (Resident #35)</p> <p>Findings include:</p> <p>The record for Resident #35 was reviewed on 9/30/13 at 11:12 A.M. Diagnoses included, but were not limited to quadriplegia at C5, chronic spacticity, pressure ulcer to buttock, pressure ulcer to ankle, general muscle weakness, chronic osteomyelitis pelvic region and thigh, and personal history of noncompliance with medical treatment, presenting hazards to health.</p> <p>On 9/24/13, the resident went to the</p>	F000314	F 314 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Registered Nurse #5 was in-serviced on 10/02/2013 related to policy and procedure for clean dressing change, specifically hand washing between glove change. Licensed nurses were in-serviced on 10/23/2013 by the DON related clean dressing change, specifically hand washing between glove change. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure for clean dressing changes. SDC and/or designee will complete clean dressing change competencies with each licensed nurses by 11/02/2013 to ensure following policy and procedure related to clean	11/02/2013	

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	<p>wound center for evaluation and treatment of pressure ulcers. He had treatment completed to the following areas:</p> <ol style="list-style-type: none"> 1. Left ischial (buttock) pressure ulcer, which was a Stage 4 (wound went to the bone or was covered with black or yellow debris tissue) 2. Right heel pressure ulcer, which was a Stage 4 3. Right medial ankle pressure ulcer, which was a Stage 4 4. Right lateral ankle pressure ulcer, which was a Stage 3 (wound went to the subcutaneous tissue, muscle or tendons). <p>The following were physician's orders for the residents pressure ulcers:</p> <ol style="list-style-type: none"> 1. Left thigh skin care indicated to cleanse with normal saline then apply silver alginate rope dressing (antimicrobial dressing) loosley into undermining located at the 10-1 o' clock position. Change the dressing daily and as needed and cover with an ABD (abdominal) pad. 2. Right medical ankle indicated to cleanse the area with normal saline then apply collagen with silver (prism) dressing. Cover with fluff and roll with guaze and secure with tubigrip and 		<p>dressing changes. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. Licensed nurses were in-serviced on 10/23/2013 by the DON related to dressing change policy and procedure. SDC and/or designee will complete dressing change observations with each nurse by 11/2/2013 to ensure compliance. SDC and/designee will complete random dressing change observations 2 times weekly for 30 days then monthly for 5 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. SDC and/or designee will conduct dressing change competencies as outlined above and report findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations to ensure continued compliance. State of compliance: 11/2/2013</p>		

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	<p>change every other day.</p> <p>3. Right lateral ankle indicated to cleanse the wound with normal saline. Apply collagen with silver (prism) dressing. Cut to size and cover with guaze and foam pad then roll guaze. Change dressing every other day.</p> <p>4. Right heel indicated to cleanse the right heel with normal saline. Apply collagen with silver (prism) dressing then cover with fluffed guaze and roll guaze. Secure with tubigrip. In addition of foam pad over the inner and outer ankle and pad heel well with guaze fluffs with dressing change every other day.</p> <p>During an observation on 10/2/13 9:50 A.M., RN #5 changed the residents pressure ulcer dressings.</p> <p>1. Left ischial pressure ulcer dressing change-RN #5 prepared the resident then washed her hands for 15 seconds before the procedure and donned clean gloves. She removed the soiled dressing, then removed her soiled gloves, then donned a pair of clean gloves. She cleansed the wound with a normal saline bullet (a vial of normal saline) and 4 x 4 guazes, then removed her soiled</p>						

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	<p>gloves then donned a pair of clean gloves. She packed the wound with a sterile q-tip and silver alginate rope dressing, then removed her gloves. She donned a pair of clean gloves and applied Exu-dry dressing placed on top of two 4 x 4 quaze square dressings and secured the dressing with cover all tape. She removed her gloves and cleaned up her area then washed her hands for 15 seconds.</p> <p>2. Right lateral ankle pressure ulcer dressing change-RN #5 prepared the resident then washed her hands for 15 seconds before the procedure. She donned a pair of clean gloves. She removed the soiled dressing then removed her soiled gloves and donned a pair of clean gloves. She cleansed the wound with a normal saline bullet and 4 x 4 guazes. She removed her soiled gloves and donned a pair of clean gloves. She cut a piece of prism dressing to fit the wound and applied it over the wound. She placed 4 x 4 guaze pads and a 4 x 4 foam pad over the lateral ankle wound. She removed her soiled gloves.</p> <p>3. Right medial ankle pressure ulcer dressing change-RN #5 donned a pair of clean gloves. She cleansed the wound with a normal saline bullet</p>			

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	<p>and 4 x 4 guazes. She removed her soiled gloves and donned a pair of clean gloves. She cut a piece of prism dressing to fit the wound and applied it over the wound. She placed 4 x 4 guaze pads and a 4 x 4 foam pad over the medial ankle wound. She removed her soiled gloves.</p> <p>4. Right heel pressure ulcer dressing change-RN #5 donned a pair of clean gloves. She cleansed the wound with a normal saline bullet and 4 x 4 guazes. She removed her soiled gloves and donned a pair of clean gloves. She cut a piece of prism dressing to fit the wound and applied it over the wound. She placed two packages of 4 x 4 guaze pads and a 4 x 4 foam pad over the heel wound. She wrapped from the middle of the right foot to the middle of the right lower extremity with kerlix guaze wrap. She removed her soiled gloves and applied two pieces of white tape to secure the kerlix wrap on the right lower extremity. She applied the tubigrip from the right foot to the knee area. She repositioned the resident and cleaned the work area. She washed her hands for 15 seconds before leaving the resident's room.</p> <p>During an interview on 10/2/13 at</p>			

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	<p>10:23 A.M., RN #5 indicated she washed her hands before and after each dressing change and then she changed gloves during the dressing changes.</p> <p>During an interview on 10/2/13 at 10:30 A.M., the Cedarwood Unit Manager indicated RN #5 should have washed her hands during the dressing changes not just before and after the dressing changes.</p> <p>On 10/2/13 at 10:00 A.M., the Director of Nursing (DON) provided the policy titled "Hand Washing And Use Of Gloves".</p> <p>The policy stated, "...The greatest danger to the resident is when gloves aren't changed or hands aren't washed between residents...Handwashing will be performed... 3. Before and after touching wounds. 4. After contact with surfaces or items which are contaminated with blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin...."</p> <p>On 10/2/13 at 11:16 A.M., the DON provided a policy titled "Dressing, Dry/Clean".</p> <p>The policy stated, "The purpose of</p>			

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	<p>this procedure is to provide guidelines for the application of dry, clean dressings... 8. Put on clean gloves. Loosen tape and remove soiled dressing... 10. Wash and dry your hands thoroughly."</p> <p>3.1-40(a)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to ensure that medication was not left at the bedside for 1 of 43 residents observed for hazards in a sample of 43 residents. (Resident #45)</p> <p>Findings include:</p> <p>During an observation on 9/25/13 at 4:08 P.M., a full vial of ipratropium bromide (bronchodilator) 0.5 milligrams and albuterol sulfate (bronchodilator) 3 milligrams in 3 milliliters was observed lying on the table next to the resident's nebulizer machine. The resident was lying down on her bed with the nebulizer machine running unsupervised.</p> <p>The resident's record was reviewed on 10/1/13 at 4:55 P.M. Diagnoses included, but were not limited to, congested heart failure, chronic airway obstruction, and apnea.</p> <p>The resident had an physicians order dated 12/27/12 for albuterol</p>	F000323	F 323 What corrective action(s) will be accomplished for those residents to have been found to have been affected by the deficient practice? The nebulizer vial was immediately removed from the room of resident #45. Licensed nurses were in-serviced on 10/23/2013 by the DON related to the policy and procedure of proper supervision when administering medications. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken. A facility wide room check was conducted on 9/26/2013 by DON and UM's to ensure no medications were left at bedside. Licensed nurses were in-serviced on 10/23/2013 by the DON related to the policy and procedure of proper supervision when administering medication. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. Licensed nurses were in-service on 10/23/2013 by the DON related to policy and procedure of proper supervision when administering medication.	11/02/2013			

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	<p>(bronchodilator)-ipratropium (bronchodilator) 2.5 milligrams/3 milliliters give by nebulizer machine four times a day. Lung assessment before and after treatment.</p> <p>On 9/25/13 at 4:08 P.M., the resident indicated she placed the medication in the machine herself and turned the machine on and off herself. She indicated the nurses would leave the medication by her machine for her to place the medication in the machine when she was ready to do her treatment.</p> <p>During an interview on 9/25/13 at 4:30 P.M., the Cedarwood Unit Manager indicated after she looked at the resident's record that she did not have a care plan or a physician order that indicated she could take a nebulizer treatment unsupervised. She indicated the medication should not have been at the bedside without a self administration order, assessment and care plan.</p> <p>A policy was provided titled "Nebulizer Therapy" on 9/25/13 at 4:50 P.M., by the Director of Nursing and deemed current. The policy states, "... 5. The clinician preparing the medication is responsible for administering it... 9. Have the patient in a sitting position...</p>		<p>SDC and/or designee will complete medication administration observations on each nurse by 11/2/2013 to ensure compliance. The SDC and/or designee will complete random medication administration observation 2 times weekly for 30 days then monthly for 5 months. Further education and/or disciplinary action will be provided as needed for issues noted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON and/or designee will conduct medication administration observations as outlined above and report findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations to ensure continued compliance. Date of compliance: 11/2/2013</p>		

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	<p>16. Nebulize solution for approximately 10 minutes or until all of the solution has been administered. If there is no visible mist leaving the nebulizer... Stop treatment if the resident's condition deteriorates and performs the necessary steps to stabilize the resident...."</p> <p>3.1-45(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to follow-up with the Physician regarding Pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident #49).</p> <p>Findings include:</p> <p>The clinical record of resident #49 was reviewed on 10/1/13 at 2:30 p.m.</p>	F000329	F 329 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As stated in the 2567, the order for the reduction of Seroquel was obtained on 8/1/2013. Unit managers, Social services, and the ward clerk were in-serviced on 10/2/2013 related to physician notification and response to pharmacy recommendations. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective	11/02/2013			

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	<p>Diagnoses included, but were not limited to, diabetes, depression, anxiety, mental disorder, delusions, and dementia.</p> <p>A Medication Regimen Review dated May 29, 2013 through September 24, 2013, indicated the following:</p> <p>May 29, 2013: Suggestion regarding seroquel.</p> <p>June 25, 2013: repeat suggestion.</p> <p>July 23, 2013: repeat suggestion.</p> <p>A Consultant Pharmacist's recommendation to Inter-disciplinary Team dated 5/30/13, indicated "Resident has been receiving Seroquel [an antipsychotic] 100 mg [milligrams] QAM [every morning] and 150 QHS [every night] for "delusions." [sic] since 7.12. Please evaluate for dosage reduction at this time. If to be continued, please provide rational." There was no response from the physician or follow-up by the facility.</p> <p>A Consultant Pharmacist's recommendation to Inter-disciplinary Team dated 7/23/13, indicated "Resident has been receiving Seroquel [an antipsychotic] 100 mg [milligrams] QAM [every morning] and</p>		<p>actions will be taken. Unit managers, Social services, and the ward clerk have been in-serviced related to physician notification and response to pharmacy recommendations. An audit was completed on 10/15/2013 by the DON and ward clerk of the pharmacy recommendations for the prior two months to ensure that physician notification was made and a response was received. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. The unit managers, social services, and the ward clerk were in-serviced by the DON on 10/2/2013 related to physician notification and response to pharmacy recommendations. The DON and/or designee will review all pharmacy recommendations monthly x 6 months to ensure that the physician is notified and that responses are received. Further education and/or disciplinary action will be provided as needed for issues noted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON and/or designee will review all pharmacy recommendations as outlined above and report findings to the Performance Improvement Committee monthly x 6 months for further review recommendation to ensure</p>		

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	<p>150 QHS [every night] for "delusions." [sic] since 7.12. Please evaluate for dosage reduction at this time. If to be continued, please provide rational." There was no response from the physician or follow-up by the facility.</p> <p>A Physician's order dated 8/1/13 indicated, "DC [discontinue] current Seroquel. Start Seroquel 100 mg 1 tab [tablet] po [by mouth] BID [twice a day]." This order was written two months after the pharmacy request.</p> <p>During an interview with the Director of Nursing on 10/2/13 at 10:30 a.m., she indicated there was no information regarding the notification of the physician of the pharmacy recommendations to reduce the seroquel dosage.</p> <p>3.1-48(a)</p>		continued compliance. Date of compliance: 11/2/2013		

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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 Based on observation, interview, and record review the facility failed to ensure foods were dated and labeled properly, that milk was stored with the proper expiration date, kitchen appliances were cleaned, and dented cans were removed from stock for 1 of 1 kitchens observed for sanitation and food storage. This deficit practice had the potential to affect 111 residents out of 114 residents in the facility.</p> <p>Findings include:</p> <p>On 9/23/13 at 9:55 A.M., the kitchen tour started with the Dietary Manager.</p> <p>1. A bag of unidentified brown diced pieces were observed sitting on the shelf in the cooler in a ziplock bag with no date and unlabeled.</p> <p>During an interview, the Dietary Mangager indicated this item was diced turkey and it did not have a date or label on the bag.</p>	F000371	F371 Plan of Correction 10/24/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The ziplock bag of turkey, sherbet, nutritional treat, ice cream, outdated milk, and the dented cans were all immediately discarded. The stove and cereal cart were cleaned on the day of the tour. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents (except those that are NPO) have the potential to be affected. The dietary staff will be in-serviced by the Registered Dietician on the food storage policy and procedure. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? The dietary staff will be in-serviced by the Registered Dietitian by November 2, 2013 on labeling and dating foods when stored, dented cans, and the cleaning schedules related to the cleanliness of the stove and cereal cart. The	11/02/2013			

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	<p>2. During an observation one raspberry sherbert, one nutritional treat, and two vanilla ice creams were sitting on the shelf in the freezer without an expiration date or a date when they were placed in the cooler.</p> <p>During an interview, the Dietary Manager indicated these items had been taken out of the box and placed on the shelf and she could not find an expiration date or a date that they were placed in the freezer.</p> <p>3. During an observation, 50 (237 milliliter) skim milks were observed in a milk crate in the cooler with a use by date of 9/20/13.</p> <p>During an interview, the Dietary Manager indicated the milks had expired dates on them and the milk delivery person should have pulled those milks the last time he delivered new milk.</p> <p>4. During an observation the stove top had white and brown dried substance on it.</p> <p>During an interview, the Dietary Manager indicated the stove is cleaned every Tuesday and it was in need of being cleaned.</p>		<p>Dietary Director will conduct kitchen and pantry rounds daily M-F to ensure food is properly stored, labeled, no dented cans are present, and to monitor the cleanliness of the kitchen equipment and storage areas. This audit will occur daily for 30 days, then weekly for 30 days, then monthly for 4 months. The Registered Dietitian will conduct kitchen and pantry rounds 3 days weekly x 90 days, then monthly. Further education and disciplinary action will be provided as needed for issues noted. Findings will be submitted to the Executive Director. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Executive Director will forward the results of the rounds to the Performance Improvement Meeting monthly for 6 months for further review and recommendations and to ensure continued compliance. Date of Compliance - 11/02/2013</p>		

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	<p>5. The cereal cart was observed to have hard yellow debris around the edges of the cart handles and cereal (corn flakes, rice krispies, total, and cheerios) scattered on the bottom of the cereal storage area and the top shelf of the cart.</p> <p>During an interview, the Dietary Manager indicated the cereal cart was to be cleaned monthly, but it was overdue for a cleaning. She indicated the yellow hard debris was glue where the cart was glued back together around the handles.</p> <p>6. During an observation of the dry storage room, two dented cans of mandarin oranges were observed on the shelf.</p> <p>During the interview, the Dietary Manager indicated she did not realize she could not use dented cans. She indicated she thought the cans had to have a hole in them to be considered unusable. She indicated she was the person who placed the dented cans on the shelf.</p> <p>On 9/26/12 at 1:00 P.M., a policy titled "Food Storage" was provided by the Dietary Manager.</p>						

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	<p>The policy stated, "...15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 48 hours or discarded...."</p> <p>3.1-21(g)(3)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 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 expired flu vaccines were destroyed or returned to the</p>	F000431	F 431 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The 5 vials of influenza vaccine	11/02/2013			

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	<p>dispensing pharmacy, located in 1 of 2 medication storage rooms.</p> <p>Findings include:</p> <p>On 9/26/13 at 1:55 p.m., during and observation of the medication storage room on Birchwood unit it was observed that the locked refrigerator contained 4 vials of influenza virus vaccine (fluvirin), with an expiration date of 6/13 and 1 vial of influenza virus vaccine (IVF/flulaval), with an expiration date of 6/13.</p> <p>On 9/26/13 at 2:05 p.m., during an interview, with Birchwood Unit Manager, she indicated the Birchwood Unit had not given any flu vaccines since last flu season and that the expired vaccines should have been destroyed.</p> <p>A policy titled "Storage of Medications" was provided by the Director of Nursing (DoN), on 10/1/13 at 3:00 p.m., and deemed current. The policy indicated : "... 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed..... "</p> <p>3.1-25(o)</p>		<p>were immediately removed from the refrigerator and disposed of. An inspection of all medication refrigerators was conducted on 9/26/2013 by the DON and Unit Managers to ensure there were no expired medications. SDC was in-serviced on 9/26/2013 related to policy and procedure pertaining to proper destruction of expired medications. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure pertaining to proper destruction of expired medications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. An inspection of all medication refrigerators was conducted on 9/26/2013 by the DON and Unit Managers to ensure there were no expired medications. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure pertaining to proper destruction of expired medications. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure pertaining to proper destruction of expired medications. The DON and/or designee will conduct inspections of medication refrigerators 2</p>				

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			times per for 30 days, then weekly for 30 days, then monthly x 4 months. Further education and/or disciplinary action will be provided for any issues noted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON and/or designee will conduct inspections of the medication refrigerators as outlined above and report findings to the Performance Improvement Committee monthly x 6 months for further review and recommendation to ensure continued compliance. Date of compliance: 11/2/2013	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review the facility failed to</p>	F000441	F 441 What corrective action(s) will be accomplished for those	11/02/2013			

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	<p>ensure appropriate handwashing was completed during a dressing change for 1 of 1 resident being observed for dressing changes in a sample of 1. (Resident #35)</p> <p>Findings include:</p> <p>The record for Resident #35 was reviewed on 9/30/13 at 11:12 A.M. Diagnoses included, but were not limited to quadriplegia at C5, chronic spacticity, pressure ulcer to buttock, pressure ulcer to ankle, general muscle weakness, chronic osteomyelitis pelvic region and thigh, and personal history of noncompliance with medical treatment, presenting hazards to health.</p> <p>On 9/24/13, the resident went to the wound center for evaluation and treatment of pressure ulcers. He had treatment completed to the following areas:</p> <ol style="list-style-type: none"> 1. Left ischial (buttock) pressure ulcer, which was a Stage 4 (wound went to the bone or was covered with black or yellow debris tissue) 2. Right heel pressure ulcer, which was a Stage 4 3. Right medial ankle pressure ulcer, which was a Stage 4 		<p>residents found to have been affected by the deficient practice? Resident #45 shows no signs or symptoms of infection. Registered Nurse #5 was in-serviced on 9/5/2013 by the DON related to policy and procedure regarding appropriate hand washing during clean dressing change. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure regarding appropriate hand washing during clean dressing change. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Licensed nurses were in-serviced on 10/23/2013 by the DON related to policy and procedure regarding appropriate hand washing during clean dressing change. All residents with dressing change orders have the potential to be affected. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur. Licensed nurses were in-serviced on 10/23/2013 by the DON on the dressing change policy and procedure. SDC and/or designee will complete dressing change observations on each nurse by 11/2/2013 to ensure compliance. SDC and/or designee will complete random dressing change observations 2 times weekly x 30 days then</p>	

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	<p>4. Right lateral ankle pressure ulcer, which was a Stage 3 (wound went to the subcutaneous tissue, muscle or tendons).</p> <p>The following were physician's orders for the residents pressure ulcers:</p> <ol style="list-style-type: none"> 1. Left thigh skin care indicated to cleanse with normal saline then apply silver alginate rope dressing (antimicrobial dressing) loosely into undermining located at the 10-1 o' clock position. Change the dressing daily and as needed and cover with an ABD (abdominal) pad. 2. Right medical ankle indicated to cleanse the area with normal saline then apply collagen with silver (prism) dressing. Cover with fluff and roll with gauze and secure with tubigrip and change every other day. 3. Right lateral ankle indicated to cleanse the wound with normal saline. Apply collagen with silver (prism) dressing. Cut to size and cover with gauze and foam pad then roll gauze. Change dressing every other day. 4. Right heel indicated to cleanse the right heel with normal saline. Apply collagen with silver (prism) 		<p>monthly x 5 months. Further education and/or disciplinary action will be provided for any issues noted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. SDC and/or designee will conduct clean dressing change competencies as outlined above and report findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations to ensure continued compliance. Date of compliance: 11/2/2013</p>	

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	<p>dressing then cover with fluffed guaze and roll guaze. Secure with tubigrip. In addition of foam pad over the inner and outer ankle and pad heel well with guaze fluffs with dressing change every other day.</p> <p>During an observation on 10/2/13 9:50 A.M., RN #5 changed the residents pressure ulcer dressings.</p> <p>1. Left ischial pressure ulcer dressing change-RN #5 prepared the resident then washed her hands for 15 seconds before the procedure and donned clean gloves. She removed the soiled dressing, then removed her soiled gloves, then donned a pair of clean gloves. She cleansed the wound with a normal saline bullet (a vial of normal saline) and 4 x 4 guazes, then removed her soiled gloves then donned a pair of clean gloves. She packed the wound with a sterile q-tip and silver alginate rope dressing, then removed her gloves. She donned a pair of clean gloves and applied Exu-dry dressing placed on top of two 4 x 4 quaze square dressings and secured the dressing with cover all tape. She removed her gloves and cleaned up her area then washed her hands for 15 seconds.</p> <p>2. Right lateral ankle pressure ulcer</p>			

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	<p>dressing change-RN #5 prepared the resident then washed her hands for 15 seconds before the procedure. She donned a pair of clean gloves. She removed the soiled dressing then removed her soiled gloves and donned a pair of clean gloves. She cleansed the wound with a normal saline bullet and 4 x 4 guazes. She removed her soiled gloves and donned a pair of clean gloves. She cut a piece of prism dressing to fit the wound and applied it over the wound. She placed 4 x 4 guaze pads and a 4 x 4 foam pad over the lateral ankle wound. She removed her soiled gloves.</p> <p>3. Right medial ankle pressure ulcer dressing change-RN #5 donned a pair of clean gloves. She cleansed the wound with a normal saline bullet and 4 x 4 guazes. She removed her soiled gloves and donned a pair of clean gloves. She cut a piece of prism dressing to fit the wound and applied it over the wound. She placed 4 x 4 guaze pads and a 4 x 4 foam pad over the medial ankle wound. She removed her soiled gloves.</p> <p>4. Right heel pressure ulcer dressing change-RN #5 donned a pair of clean gloves. She cleansed the wound with</p>				

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	<p>a normal saline bullet and 4 x 4 guazes. She removed her soiled gloves and donned a pair of clean gloves. She cut a piece of prism dressing to fit the wound and applied it over the wound. She placed two packages of 4 x 4 guaze pads and a 4 x 4 foam pad over the heel wound. She wrapped from the middle of the right foot to the middle of the right lower extremity with kerlix guaze wrap. She removed her soiled gloves and applied two pieces of white tape to secure the kerlix wrap on the right lower extremity. She applied the tubigrip from the right foot to the knee area. She repositioned the resident and cleaned the work area. She washed her hands for 15 seconds before leaving the resident's room.</p> <p>During an interview on 10/2/13 at 10:23 A.M., RN #5 indicated she washed her hands before and after each dressing change and then she changed gloves during the dressing changes.</p> <p>During an interview on 10/2/13 at 10:30 A.M., the Cedarwood Unit Manager indicated RN #5 should have washed her hands during the dressing changes not just before and after the dressing changes.</p>			

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	<p>On 10/2/13 at 10:00 A.M., the Director of Nursing (DON) provided the policy titled "Hand Washing And Use Of Gloves".</p> <p>The policy stated, "...The greatest danger to the resident is when gloves aren't changed or hands aren't washed between residents...Handwashing will be performed... 3. Before and after touching wounds. 4. After contact with surfaces or items which are contaminated with blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin...."</p> <p>On 10/2/13 at 11:16 A.M., the DON provided a policy titled "Dressing, Dry/Clean".</p> <p>The policy stated, "The purpose of this procedure is to provide guidelines for the application of dry, clean dressings... 8. Put on clean gloves. Loosen tape and remove soiled dressing... 10. Wash and dry your hands thoroughly."</p> <p>3.1-18(l)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review the facility failed to ensure the environment was kept free of cobwebs, equipment laying on the floor, dirty floors and windows, failed to ensure personal equipment was bagged, and failed to ensure doors closed properly for 9 of 43 resident's rooms observed. (Resident #12, #35, #45, #63, #101, #112, #119, #136, and #157)</p> <p>Findings include:</p> <p>1. During an observation on 9/24/13 at 10:33 A.M., cobwebs were observed in the upper left hand corner of the window and lower left corner of the windowsill of Resident #35's window.</p> <p>On the following dates and times, cobwebs were observed in the window on 9/24/13 at 3:30 P.M., 9/25/13 at 2:25 P.M., 9/26/13 at 9:35 A.M., and 9/27/13 at 2:15 P.M.</p> <p>2. During an observation on 9/25/13 at 4:08 P.M., a cobweb was observed that extended from the right hand</p>	F000465	F 465 Plan of Correction 10/24/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The cobwebs observed in the windowsill of Resident #35's window have been removed. The cobweb observed in the windowsill of Resident #45's room was removed. The wash basin under that was lying under the sink on the floor in Resident #101's bathroom has been removed. The green denture cup with a white lid has been removed from the floor under Resident #112's head of the bed. The wash basin lying on the floor under the bathroom sink in Resident #136's room has been removed. The un-bagged toilet plungers in #12, #112's, and #157's have been removed. The urinal and measuring hat observed un-bagged have been removed from Resident #35's bathroom and the un-bagged urinal in #136's room has been removed. The debris observed on the floor of the empty closet in Resident #35's room was removed. The clouded window with no visibility in Resident #63's room has been replaced. The door in Resident	11/02/2013			

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	<p>corner of the middle window to the middle of the last window on the bottom of the windowsill of Resident #45's window.</p> <p>During the interview with the Housekeeping and Laundry Manager on 9/27/13 at 1:37 P.M., she indicated the left hand corner of the upper window in Resident #35's window had a cobweb in it. She indicated the rooms are cleaned daily and cobwebs are swept daily when the rooms are cleaned.</p> <p>3. During an observation on 9/24/13 at 3:20 P.M., a wash basin was observed lying under the sink on the floor in Resident #101's bathroom.</p> <p>4. On the following dates and times, a green plastic denture cup with a white lid was observed lying on the floor under Resident #112's head of the bed on 9/23/13 at 1:50 P.M., 9/23/13 at 4:25 P.M., 9/24/13 at 11:25 A.M., 9/24/13 at 3:15 P.M., and 9/25/13 at 11:08 A.M.</p> <p>During an interview on 9/25/13 at 11:14 A.M., the Cedarwood Unit Manager indicated the denture cup should not have been under the bed. She indicated housekeeping had not cleaned under the bed.</p>		<p>3119's room was adjusted so that it is working correctly and not sticking. The black weather strip on Resident #157's window has been replaced with new strip. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An inspection of the facility rooms was conducted by the Maintenance Man. Housekeeping/Laundry Supervisor, and Administrator. Area's identified with similar issues that were observed during the Survey have been corrected. Nursing Staff were In-serviced on 10/25/13 regarding proper storage of urinals, wash basins, and toilet plungers. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? The Housekeeping Supervisor, in-serviced the cleaning staff on the Five Step Daily Resident Room Cleaning, Discharge Room Cleaning, and the specific area's identified during the Survey. The Housekeeping Supervisor will conduct an audit of all occupied rooms M-F for 30 days, then 3 x weekly for 30 days, and 1x weekly thereafter. Further cleaning, education on procedure's, and up to disciplinary action will be provided as necessary for issues noted.</p>		

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	<p>5. On 9/24/13 at 10:05 A.M., during an observation a wash basin was observed lying on the floor under the bathroom sink in Resident #136's bathroom.</p> <p>During the interview on 10/1/13 at 5:10 P.M., the Cedarwood Unit Manager indicated the wash basins should be kept in the closets or bedside tables.</p> <p>6. On the following dates and times, a toilet plunger was observed unbagged in Resident #12's bathroom on 9/23/13 at 2:30 P.M., 9/23/13 at 4:25 P.M., 9/24/13 at 11:25 A.M., 9/24/13 at 3:15 P.M., and 9/25/13 at 11:08 A.M.</p> <p>7. On the following dates and times, a toilet plunger was observed unbagged in Resident #112's bathroom on 9/23/13 at 1:50 P.M., 9/23/13 at 4:25 P.M., 9/24/13 at 11:25 A.M., 9/24/13 at 3:15 P.M., and 9/25/13 at 11:08 A. M.</p> <p>8. During an observation on 9/25/13 at 2:25 P.M., a toilet plunger was observed unbagged under the bathroom sink in Resident # 157's bathroom.</p>			

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	<p>During an interview on 9/25/13 at 11:14 A.M., the Cedarwood Unit Manager indicated the toilet plungers were kept in the dirty utility room not in the resident's bathroom.</p> <p>9. During an observation on 9/24/13 at 10:33 A.M., a urinal and a measuring hat was observed sitting on Resident #35's toilet unbagged.</p> <p>On 9/24/13 at 10:05 A.M., an urinal was observed sitting on Resident #136's toilet unbagged.</p> <p>During an interview on 10/1/13 at 5:10 P.M., the Cedarwood Unit Manager indicated the urinals were to be bagged and kept in the bottom drawer of the bedside table when they were not being used.</p> <p>10. On the following dates and times, debris was observed on the floor of an empty closet in Resident #35's room on 9/24/13 at 10:33 A.M., 9/24/13 at 3:30 P.M., 9/25/13 at 2:25 P.M., 9/26/13 at 9:35 A.M., and 9/27/13 at 2:15 P.M.</p> <p>During an interview on 9/27/13 at 1:37 P.M., the Housekeeping and Laundry Manager indicated the rooms are cleaned daily and once a month they are deep cleaned. She indicated</p>			

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	<p>the housekeepers would have found the debris on the floor in the empty closet when they deep cleaned that room the next time.</p> <p>11. During an observation on 9/24/13 at 11:15 A.M., Resident #63's right sided window was clouded with no visibilitiy.</p> <p>During an interview on 9/24/13 at 11:15 A.M., the resident indicated she had told one of the maintenance workers about the window approximately three months ago then again one month ago. She indicated he was going to change the window.</p> <p>During the environmental tour on 9/27/13 at 10:15 A.M., Maintenance #4 indicated he was not aware of this problem, but he would get the window replaced.</p> <p>12. On 9/26/13 at 11:05 A.M., Resident #119's room door was observed to have stuck when trying to be opened.</p> <p>During an interview on 9/26/13 at 11:05 A.M., the resident indicated the door would stick when he tried to open it.</p> <p>During an interview on 9/26/13 at</p>			

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	<p>11:30 A.M., the Administrator indicated he was not aware that the resident's door was sticking, but he would have the maintenance man fix it now.</p> <p>13. On 9/25/13 at 2:25 P.M., the black weather strip on the left hand side of Resident #157's window was coming off at the bottom of the window.</p> <p>During an interview on 9/25/13 at 2:25 P.M., the resident indicated she had told a CNA approximately three months ago about the strip. She indicated that during the summer months black bugs had come into her room through that area.</p> <p>During the environmental tour on 9/27/13 at 10:15 A.M., Maintenance #4 indicated he was not aware of this problem, but he would get it fixed.</p> <p>A policy provided on 10/1/13 at 9:36 A.M., by the Housekeeping and Laundry Manager titled "Discharge Room Cleaning" and deemed to be current, stated "... Be sure the closet is emptied and disinfected..."</p> <p>A policy provided on 10/1/13 at 9:36 A.M., by the Housekeeping and Laundry Manager titled "Five Step</p>			

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	<p>Daily Resident Room Cleaning" and deemed to be current, stated "... Using a solution of proper diluted germicide, sanitized all horizontal surfaces. As you enter the room, work clockwise around the room hitting all surfaces. Tabletops, headboards, windowsills, chairs-should all be done. ... Vertical surfaces are not completely wiped down daily-but must be spot-cleaned daily... The entire floor must be dust mopped-especially behind dressers and beds... The most important area of a resident's room to disinfect is the floor. This is where most air-borne bacteria will settle and so it needs to be sanitized daily..."</p> <p>This Federal tag relates to Complaint IN00135681.</p> <p>3.1-19(f)</p>			

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