

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711
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F000000	<p>This visit was for a recertification and state license survey.</p> <p>Survey Dates: August 18, 19, 20, 21, 22, 25, 26, 2014</p> <p>Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540</p> <p>Survey Team: Martha Saull, RN TC Julie Call, RN Sue Brooker, RD Virginia Terveer, RN</p> <p>Census Bed Type: SNF: 36 SNF/NF: 80 Residential: 69 Total: 185</p> <p>Census Payor Type: Medicare: 14 Medicaid: 37 Other: 134 Total: 185</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p>	F000000		
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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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F000282 SS=D	<p>Quality review completed on August 29, 2014 by Randy Fry RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to follow a physician's order for a fluid restriction for 1 of 1 resident (Resident #129) reviewed for dialysis. The facility also failed to follow a physician's order to mix Miralax in 8 ounces of fluid for 1 resident (Resident #129).</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #129 on 8/20/14 at 8:45 a.m., indicated the following: diagnoses included, but were not limited to, renal failure, renal dialysis status, neoplasms of bladder, history of malignant neoplasm of prostate, diabetes mellitus, and unspecified nutritional deficiency.</p> <p>A physician's order for Resident #129, dated 5/20/14, indicated 1200 cc (cubic</p>	F000282	<p>1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. a) The licensed nurses administering medications to Resident #129 were immediately reminded to ensure that physician's orders are followed regarding a fluid restriction and Miralax powder administration. b) The Fluid Distribution Plan was created and care planned for the Resident #129 on a fluid restriction on 8/25/14. The licensed nurses taking care of Resident #129 were instructed on the plan (See Form #1). c) The Daily Fluid Intake Monitoring sheet was initiated for the Resident #129 to ensure a better monitoring of a fluid restriction. (See Form #2). d) To ensure that the physician's orders are followed, Nepro supplement and Prostat supplement were added to the fluid count on the Daily Fluid Intake Monitoring sheet. e) The</p>	09/25/2014

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	<p>centimeters) fluid restriction. The orders also indicated to document cc's consumed on I & O (intake and output) sheet.</p> <p>A Nutrition Assessment for Resident #129, dated 5/22/14, indicated he received a Regular No Concentrated Sweets, No Added Salt, low potassium, low phosphorus diet with snacks at 10 AM - 2 PM - 7 PM and a 1200 cc fluid restriction. The assessment also indicated dietary was to provide 240 ml (milliliter) with each meal for a total of 720 ml/day and nursing to provide the remaining 480 ml of fluids. The assessment further indicated no water pitcher in room.</p> <p>A physician's order for Resident #129, dated 5/22/14, indicated to add Nepro (a renal supplement) 120 ml at HS (hour of sleep), increasing the fluid provided by nursing service to 600 ml in a 24 hour period. The order did not indicate the 120 ml of Nepro was not to be included in his fluid restriction.</p> <p>A physician's order for Resident #129, dated 6/9/14, indicated Polyethylene Glycol (Miralax) 17 grams mixed with 8 ounces of water, juice, soda, coffee or tea daily, increasing the fluid provided by nursing service to 840 ml in a 24 hour period.</p>		<p>Meal Service Verification Sheet was updated to indicate Resident #129 is on a 1200 mL fluid restriction. (See Form #3). According to the physician's order, Miralax was discontinued on 9/8/14 for Resident #129 due to the fluid requirements for Miralax powder; stool softener is in place. Plan of care updated on 9/8/14 to reflect the above changes. 2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected. a) The Fluid Distribution Plan was initiated for all residents on a fluid restriction. The Daily Fluid Intake Monitoring sheets were implemented for all residents on a fluid restriction. The Meal Service Verification Sheet was updated to reflect all residents on a fluid restriction. b) The amount of fluids given with Miralax is documented in the electronic medication record for all residents receiving Miralax powder starting 9/4/14. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have</p>				

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	<p>A Nutrition Assessment for Resident #129, dated 6/12/14, indicated he remained on the therapeutic diet for dialysis. The assessment also indicated he was on a 1200 cc fluid restriction and was supplemented with Nepro 120 ml HS. The assessment further indicated the dialysis center recommended Prostat (liquid protein supplement) SF (sugar free) 30 ml BID (twice a day) be added.</p> <p>A physician's order for Resident #129, dated 6/12/14, indicated Prostat Sugar Free 30 ml BID, increasing the fluid provided by nursing service to 900 ml in a 24 hour period. The order did not indicate the 60 ml of Prostat was not to be included in his fluid restriction.</p> <p>Calculations indicated Resident #129 would receive 1620 cc's per day from dietary and nursing.</p> <p>Nutrition Assessments for Resident #129, dated 7/4/14 and 7/30/14, indicated he remained on the therapeutic diet. The assessments also indicated the total amount of fluids accepted at mealtime was between 1000-1100 ml per day.</p> <p>A Meal Service Verification Sheet in the Lavendel dining room did not indicate Resident #129 was on a 1200 cc fluid</p>		<p>made. a) The Administration of Medications has been updated on 9/5/14 to indicate that all medications and treatments shall be administered according to the physicians' orders (See Form #4; line 9). The Hydration Policy and Procedure was updated on 9/4/14 to reflect the plan for monitoring fluid intakes for residents on a fluid restriction and the use of bowel aids in residents on fluid restrictions (See Form #4; lines 11/12). b) The nursing staff will be re-educated on 9/17/14 on the proper monitoring of residents on fluid restrictions, following the physician's orders, the use of bowel aids in residents on fluid restrictions, and potassium rich foods. d) New nursing employees will be oriented on the administration of medications per the physicians' orders and the fluid restriction monitoring. This has been added to the new nursing employee orientation (See Forms #6 and #7). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. a) Residents on a fluid restriction will be audited by Director of Healthcare Services and/or her designee on a weekly basis during the healthcare management meeting to ensure that the physicians' orders are followed. b) Unit managers on each unit will audit residents on a</p>				

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	<p>restriction.</p> <p>Review of the Medication Administration Record for Resident #129 indicated the Miralax was given in 8 ounces of fluid as ordered.</p> <p>Review of the Administration Documentation History Detail Reports for Resident #129, dated for the month of August, 2014, indicated he received the 120 ml Nepro and the 30 ml Prostat BID as ordered.</p> <p>Review of the Intake Report for Resident #129 for the month of August, 2014, indicated the following:</p> <ul style="list-style-type: none"> - On 8/4/14 he received 1920 cc's of fluid provided between the Certified Nursing Assistants (CNAs) and the nursing staff. - On 8/5/14 he received 1700 cc's of fluid provided between the CNAs and the nursing staff. - On 8/6/14 he received 1630 cc's of fluid provided between the CNAs and the nursing staff. - On 8/7/14 he received 1720 cc's of fluid provided between the CNAs and the nursing staff. 		<p>fluid restriction monthly with QA Checklist to ensure that physicians orders are being followed (See Form #8). c) Unit managers on each unit will audit on a monthly basis that the appropriate amount of fluids are given to residents receiving Miralax powder to ensure that physicians' orders are being followed (See Form #8).</p>		

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	<p>- On 8/8/14 he received 1710 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>- On 8/9/14 he received 2140 cc's of fluid provided between the CNAs and the nursing staff</p> <p>- On 8/10/14 he received 1440 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>- On 8/11/14 he received 2080 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>- On 8/12/14 he received 1620 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>- On 8/13/14 he received 1470 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>-On 8/14/14 he received 1280 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>- On 8/15/14 he received 2500 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>- On 8/17/14 he received 1660 cc's of fluid provided between the CNAs and the</p>			

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	<p>nursing staff.</p> <p>- On 8/18/14 he received 1530 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>- On 8/20/14 he received 1670 cc's of fluid provided between the CNAs and the nursing staff.</p> <p>The Intake Report did not indicate if the Nepro, Prostat, and the water for the Miralax were included. The report also did not indicate if the fluid amounts documented by the CNAs were included in the fluid amounts documented by the nursing personnel.</p> <p>During an observation on 8/20/14 at 12:13 p.m. in the Lavendel dining room, Resident #129 was seated in a chair at a dining table. A 4 ounce (120 cc) glass of water was at his place setting. At 12:19 LPN #16 gave him a small medicine cup (30 ml) of liquid protein. At 12:21 p.m., he was given a 4 ounce (120 cc) glass of juice. He received a lunch meal of pork chop, scalloped potatoes, sliced tomatoes, and strawberry jello with bananas (120 cc). At 12:52 p.m., Resident #129 requested and received a 4 ounce cup of vanilla ice cream (50 cc). He left the dining room at 1:00 p.m. after consuming 100% of his food and 460 cc's of fluid.</p>			

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	<p>During an observation on 8/21/14 at 11:21 a.m. in the Lavendel dining room, Resident #129 was observed seated in a chair at a dining table. He was observed to have a 4 ounce (120 cc) glass of water at his place setting. He received a 4 ounce (120 cc) glass of juice and was provided with a small medicine cup (30 ml) of Prostat by LPN #15. At 12:20 p.m., he received his noon meal of meatloaf, mashed potatoes with gravy (30 cc), creamed peas, and a banana. At 12:39 p.m., he left the dining room after consuming 100% of his food and 300 cc's of fluids. He was observed to put the banana into his shirt pocket.</p> <p>CNA #8 was interviewed on 8/20/14 at 12:36 p.m. During the interview she indicated the Meal Service Verification Sheet in the Lavendel dining room was completed to indicate those residents who had been served their meals. She also indicated the sheet indicated what diet the residents were to receive and any dietary restrictions.</p> <p>CNA #9 was interviewed on 8/21/14 at 11:24 a.m. During the interview she indicated the small drinking glasses contained 4 ounces of liquids.</p> <p>The Administrator in Training was</p>						

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	<p>interviewed on 8/21/14 at 3:55 p.m. During the interview she indicated the facility did not have a fluid distribution plan for Resident #129 since all fluids were served by nursing. She also indicated all fluids were recorded on the intake record. The CNAs recorded fluid intake for meals and the nursing staff recorded the fluid intake during medication pass and snacks.</p> <p>The Administrator in Training and the Director of Nursing were interviewed on 8/22/14 at 10:00 a.m. During the interview they indicated the Nepro, the Prostat, and the 8 ounces of fluid to be mixed with the Miralax had not been included in Resident #129's fluid restriction.</p> <p>A facility care plan for Resident #129, with a review date of 5/29/14, indicated the problem area of at risk for altered nutrition/altered hydration. Interventions to the problem included, but were not limited to, diet provided as ordered Regular No Concentrated Sweets, No Added Salt, low potassium, low phosphorus, 1200 cc fluid restriction, monitor fluid intakes, and Nepro 120 ml HS.</p> <p>A facility care plan for Resident #129, with a review date of 6/3/14, indicated</p>						

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	<p>the problem area of potential alteration in fluid status related to on a 1200 cc/day fluid restriction due to dialysis. Interventions to the problem included, but were not limited to, document resident's fluid intake with meals, to maintain 1200 cc/day fluid restriction due to dialysis, and administer Nepro 120 cc q (every) HS.</p> <p>A facility care plan for Resident #129, with a review date of 6/3/14, indicated the problem area of resident remains on a 1200 cc fluid restriction. Interventions to the problem included, but were not limited to, fluid restriction (1200 ml) daily due to dialysis, document fluid intake every shift, include fluids with meals, fluids with medication, fluids with snacks, Prostat, and supplement (Nepro).</p> <p>A facility care plan for Resident #129, with a review date of 6/3/14, indicated dialysis treatments will be effective and resident will have no concerns associated with dialysis. Interventions included, but were not limited to, fluid restriction - 1200 cc per day, and staff to keep track of fluid intake every shift.</p> <p>A current facility policy "Fluid Distribution Plan", revised on August, 2014 and provided by the Staff Development Coordinator, indicated</p>			

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	<p>"...Fluids are: Anything that is liquid at room temperature...All Beverages (Water, Milk, Juice, Coffee, Tea, Smoothies, Boost/Ensure/Health Shakes, Ice Cream, Sherbet, Soup, Jello, Creamers, Gravy)...All fluids will be offered by nursing staff at meals, snacks, and med pass...If Order for Fluid Restriction reads: 1200 ml/Total/Day...Serve with meals 780 ml: Breakfast 360 ml, Lunch 240 ml, Supper 180 ml...Fluids in-between meals, med pass, and supplements 420 ml...."</p> <p>A current facility policy "Intake & Output", revised on August, 2014 and provided by the Staff Development Coordinator, indicated "To maintain an accurate record of the patient's fluid balance...Check water pitcher, glass, coffee cups, soup dish, ice cream and milk containers for amounts consumed...Total intake at the end of each shift...Include the following foods/fluids in monitoring oral intake of residents; water, fruit juice, ice cream, tea, coffee, milk drinks, soups, ice chips, gelatin, milk...."</p> <p>2. A physician's order for Resident #129, dated 6/9/14, indicated Polyethylene Glycol (Miralax) 17 grams mixed with 8 ounces of water, juice, soda, coffee or tea daily.</p>			

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	<p>Review of the Medication Administration Record for Resident #129 indicated the Miralax was given in 8 ounces of fluid as ordered.</p> <p>During an observation on 8/20/14 at 12:13 p.m. in the Lavendel dining room, Resident #129 was seated in a chair at a dining table. A 4 ounce glass of water was at his place setting. At 12:19 p.m., LPN #16 gave him a small medicine cup of Prostat and a small medicine cup of Miralax. At 12:21 p.m., he was given a 4 ounce glass of juice. The glass of water was already consumed. At 12:28 p.m., Resident #129 was observed to pour his liquid protein and the Miralax into the approximately 3 ounces of juice remaining in his glass and drink it.</p> <p>During an observation on 8/21/14 at 11:21 a.m. in the Lavendel dining room, Resident #129 was observed seated in a chair at a dining table. He was observed to have a 4 ounce glass of water at his place setting. He received a 4 ounce glass of juice and was provided a small medicine cup of Prostat and a small medicine cup of Miralax by LPN #15. At 12:13 p.m. he was provided with his noon medications which he took with his water. There was approximately 1 ounce of water and 1 1/2 ounce of juice</p>				

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	<p>remaining in each glass. At 12:30 p.m. Resident #129 was observed to pour his liquid protein and the Miralax into the ounce of water remaining in his glass and drink it.</p> <p>The Administrator in Training and the Director of Nursing were interviewed on 8/22/14 at 10:00 a.m. During the interview they indicated physician orders were to be followed.</p> <p>A facility policy for Resident #129, with a review date of 6/3/14, indicated the problem area of altered bowel elimination. Interventions to the problem included, but were not limited to, medicate as ordered by physician.</p> <p>A current facility policy "Policy and Procedure for the Administration of Medications", revised on December, 2012, and provided by the Administrator in Training on 8/22/14 on 11:48 a.m., indicated "...An accurate and complete record shall be kept of all medication and therapy...."</p> <p>3. During an observation on 8/20/14 at 12:19 p.m., Nurse #16 delivered Resident #129's Miralax Powder in a plastic medication cup and placed it on the table. The Nurse #16 instructed Resident #129 to put the powder in his juice when he got it.</p>						

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	<p>An observation on 8/20/14 at 12:23 p.m. indicated the CNA staff delivered a 4 ounce glass of grape juice. Resident #129 was observed taking only sips of the grape juice until 1/2 glass of the juice remained.</p> <p>An observation on 8/20/14 at 12:30 p.m.. Resident #129's lunch meal was served and the Resident was observed to pour the Miralax Powder into 1/2 glass (2 ounces) of grape juice. The Resident drank the grape juice mixed with the Miralax Powder.</p> <p>A review of Resident #129's clinical records indicated Resident #129's diagnoses included but were not limited to, diabetes mellitus, hypertension, atrial fibrillation, congestive heart failure, renal failure and constipation.</p> <p>A review of Resident #129's physician orders, dated 8-11-14, indicated the following, "...polyethylene glycol (Miralax) 3350 17 gram/dose oral powder; give 17 gram mixed with 8 oz. (ounces) water, juice, soda, coffee or tea by oral route once daily for constipation every day at 12:00 p.m....Original Order Date: 6/12/14...."</p> <p>3.1-35(g)(2)</p>			

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F000323 SS=E	<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 the Epi-Clenz hand sanitizer, alcohol prep pads and Citrus II air freshener were secured and out of reach of confused and mobile residents who resided in 3 of 5 units (Edelweiss, Lavendel and Sonnenblum) in the facility. This deficient practice had the potential to affect 20 confused and mobile residents of the 116 residents who resided in the facility.</p> <p>Findings include:</p> <p>An observation on 8-18-2014 at 10:34 a.m., indicated two alcohol prep pads were located on top of the unattended treatment cart in Sonnenblum near rooms 348 - 358.</p> <p>An observation on 8-18-2014 at 11:38 a.m., indicated an unattended medication cart in Sonnenblum was parked near rooms 348 -358 and had 2 alcohol prep pads stored in an open container. The container was observed to be placed on</p>	F000323	<p>1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. a) On 08/25/2014 unit managers on Edelweiss, Lavendel, and Sonnenblum units reviewed 20 confused and mobile residents who could reach unsecured items. At that time all hand sanitizer, alcohol prep pads, and air fresheners were immediately secured on Edelweiss, Lavendel, and Sonnenblum units. b) Nursing staff on Edelweiss, Lavendel, and Sonnenblum units were instructed to ensure all Epi-Clenz hand sanitizer, alcohol prep pads, and Citrus II air fresheners are secured at all times and shall not be left unattended. c) Storage of Medications and Chemicals Policy was revised 09/04/2014 to reflect the labeling and storage of chemical products which includes all aerosol sprays, alcohol products, and hand sanitizers (See Form #9; line 7). 2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what</p>	09/25/2014
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	<p>the edge of the cart and within reach of residents.</p> <p>An observation on 8-19-2014 at 11:26 a.m., indicated 8 alcohol prep pads were out on top of the unattended Sonnenblum treatment cart that was parked near rooms 348 - 358. The alcohol prep pads were within reach of residents.</p> <p>An observation on 8-19-2014 at 2:18 p.m., indicated 8 alcohol prep pads were on top of the unattended Sonnenblum medication cart that was parked near rooms 348 - 358 and within reach of residents.</p> <p>An observation on 8-20-2014 at 11:25 a.m., indicated a container of Epi-Clenz hand sanitizer was out on top of the unattended medication cart in Edelweiss.</p> <p>An observation on 8-20-2014 at 11:35 a.m., indicated 8 alcohol prep pads were on top of the unattended treatment cart in Sonnenblum that was parked near rooms 348 - 358.</p> <p>An observation on 8-20-2014 at 11:45 a.m., indicated another hand sanitizer (Germ - X) was in a 1.5 oz bottle and was left out on top of the unattended Edelweiss Medication cart.</p>		<p>actions the facility took to correct the deficient practice for any resident that the facility identified as being affected. a) The Storage of Medications and Chemicals Policy was reviewed and implemented with the nursing staff on all units. b) The Director of Healthcare Services reviewed 37 confused and mobile residents on all units who could be affected by this practice. Nursing staff on all units instructed to keep hand sanitizers, air fresheners, and alcohol pads secured at all times and not left unattended. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. a) In-service scheduled on 09/17/2014 regarding the proper storage of aerosol sprays, alcohol products, and hand sanitizers will be presented to all nursing staff within the facility to ensure all staff have been appropriately educated. b) New employees will be oriented on the proper storage of chemicals. This has been added to the new nursing employee orientation (See Forms #6 and #7). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>				

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	<p>An observation on 8-20-2014 at 12:16 p.m., indicated the Germ X hand sanitizer was gone from the Edelweiss medication cart but the Epi-Clenz hand sanitizer remained out on top of the unattended medication cart.</p> <p>An observation on 8-21-2014 at 3:13 p.m., indicated 2 alcohol prep pads were out on top of the unattended treatment cart in Sonnenblum. A bottle of Epi-Clenz hand sanitizer was observed in the side compartment of the treatment cart. Both the alcohol pads and hand sanitizer were in reach of residents.</p> <p>An observation on 8-21-2014 at 3:20 p.m., indicated a 7 ounce spray can of Citrus II, an odor destroyer, was in the side compartment of the unattended treatment cart in Edelweiss where it was accessible to residents. The can had a warning on the label "keep out of reach of children."</p> <p>An observation on 8-22-2014 at 9:30 a.m., indicated a 7 ounce can of Citrus II was in the unattended Edelweiss treatment cart in the side compartment and was within reach of residents.</p> <p>An observation on 8-22-2014 at 9:32 a.m., indicated the Epi-Clenz hand sanitizer was in the side compartment of</p>		<p>program will be put in place. Unit managers or their designee on each unit to monitor proper storage of aerosol sprays, alcohol products, and hand sanitizers and complete QA audit for one time weekly for four weeks, then biweekly for two months, then monthly thereafter (See forms #10 and #8).</p>				

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	<p>the Sonnenblum unattended treatment cart and parked near rooms 348-358. The hand sanitizer was within reach of residents.</p> <p>An observation on 8-25-2014 at 9:09 a.m., indicated a 7 ounce can of Citrus II was in the side compartment in the unattended treatment cart in Edelweiss and was within reach of residents.</p> <p>An observation on 8-25-2014 at 9:15 a.m., indicated 2 bottles of Epi-Clenz hand sanitizer and an alcohol pad was out on top of the unattended medication cart in Lavendel and within reach of residents.</p> <p>An observation on 8-25-2014 at 9:20 a.m., indicated an alcohol prep pad was out on top of the unattended Sonneblum treatment cart parked near rooms 348 -358. A bottle of Epi-Clenz hand sanitizer was observed in the side compartment of the treatment cart and both the alcohol pad and hand sanitizer were within reach of residents.</p> <p>During an observation and interview with the Administrator in Training (AIT) on 8-25-2014 from 1:25 p.m. - 1:30 p.m., the following observations and interview were as follows:</p> <p>-At 1:25 p.m., the AIT was observed to</p>			

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	<p>find the Citrus II stored in the side compartments of the unattended Edelweiss medication and treatment carts. The AIT was also observed to find the Epi-Clenz hand sanitizer stored in the side compartment of the medication cart. An interview with the AIT on 8-25-2014 at 1:26 p.m., indicated these products should not be stored on the outside of the medication and treatment carts.</p> <p>-At 1:28 p.m., the AIT was observed to find the Citrus II stored in the side compartment of the unattended Lavendel treatment cart and a bottle of Epi-Clenz hand sanitizer was out on top of the unattended medication cart.</p> <p>- At 1:30 p.m., the AIT was observed to find a bottle of Epi-Clenz hand sanitizer stored in the side compartment of the unattended treatment cart in Sonnenblum near rooms 348 -358.</p> <p>On 8-25-2014 at 1:05 p.m., the AIT provided the following numbers of confused and mobile residents who resided in the following units: Edelweiss - 12 Lavendel - 5 Sonnenblum - 3</p> <p>A review of the Citrus II all natural air freshener label indicated the following:</p>			

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	<p>"...extreme danger..." and "...Keep out of reach of children...."</p> <p>A review of the EPI-CLENZ instant hand sanitizer indicated the active ingredient was "70% Ethyl Alcohol", "...Do not use in the eyes..." and "Keep out of reach of children...If swallowed get medical help or contact a Poison Control Center right away...."</p> <p>A review of the isopropyl Alcohol 70% prep pad MSDS (Material Safety Data Sheet) 090735 dated 12-12-2006 indicated "...can affect mucous tissue and/or aggravate mucous membrane dysfunction...ingestion may cause gastric distress...excessive ingestion may lead to coma or death...."</p> <p>A policy titled "Storage Areas, Environmental Services" dated November 2010 and provided by the Staff Development Coordinator on 8-25-2014 at 3:45 p.m., indicated "...nursing department storage areas shall be maintained in a clean and safe manner...."</p> <p>3.1-45(a)(1)</p>						

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F000327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was consistently provided with thickened liquids for 1 of 2 resident's reviewed for hydration. (Resident #155)</p> <p>Findings include:</p> <p>On 8/19/14 at 11 A.M., the clinical record of Resident #155 was reviewed. Diagnoses included, but were not limited to, the following: congestive heart failure and dysphagia, pharyngeal phase. The MDS (minimum data set) assessment dated 8/5/14 included, but was not limited to, the following: cognitive status was independent; eating required supervision, oversight, encouragement and/or cueing and was on a mechanical altered diet.</p> <p>Physician orders, dated 7/29/14 included, but were not limited to, the following: Bumex (diuretic) 0.5 mg twice a day, except for Mondays...Bumex 1 mg twice a day on Mondays..."</p>	F000327	<p>1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. On 8/27/14 per Speech therapy recommendations and the physician's order, Frazier Protocol was initiated for Resident #155. Resident #155 is to receive 360 mL extra fluids daily following the Frazier Protocol. Nursing staff instructed to keep nectar thickened fluids at the bedside within the resident's reach at all times. The interventions added to the resident's plan of care. 2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected. a) Director of Healthcare reviewed all residents receiving thickened fluids in the facility (8 residents total). The Policy & Procedure for Residents on Nectar Thickened Liquids was updated to indicate</p>	09/25/2014

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	<p>A Nutritional Assessment dated 7/30/14 included, but was not limited to, the following: "...BUN (blood urea nitrogen) 45 H (high)...r/t (related to) dx (diagnosis) of CKD (chronic kidney disease)...nectar thick liquids except for water...thickened liquids for swallowing ease...Estimated Nutritional Needs...Daily Fluid Volume: 1500-1900 (cc) (sic)...New Nutritional Approaches...monitor for s/s (signs and symptoms) of dehydration..."</p> <p>A Speech Therapy Evaluation and Plan of Treatment dated 7/30/14 included, but was not limited to, the following: "...Assessment summary...Impression...currently on nectar thick liquids...due to documented physical impairments and associated functional deficits, the patient is at risk for aspiration..."</p> <p>A plan of care, dated 8/5/14, included but was not limited to, the following: "Problem: Visual deficit r/t (related to) only able to (sic) objects if the right "location" with glasses. Usually sees only outlines of objects...Hx (history) of 6 eye surgeries with L (left) corneal transplants/revisions...Interventions:...Able to feed self and ambulate with walker with occasional cues of object</p>		<p>that nectar thickened liquids will be placed at bedside "within the resident's reach" (See Form #11). The Hydration Policy & Procedure was updated to indicate that water pitchers/mugs will be provided at all bedsides "within the resident's reach" (See Form #5). The policies implemented with all nursing staff on all units.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. The nursing staff will be re-educated on 9/17/14 regarding keeping water pitchers/mugs with thin or thickened water at all bedsides within the reach of residents. The nursing staff will also be in-serviced on Frazier Protocol. The new nursing employees will be oriented to keep the thickened water at bedside. This has been added to the orientation list (See Form #6).</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. Unit managers or their designee on each unit to make 5 random observations weekly for four weeks, then biweekly for two months, and monthly thereafter. Findings will be documented on QA Checklist (see Form #10).</p>				

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	<p>locations..."</p> <p>A plan of care, dated 8/7/14, included but was not limited to, the following: "Nutrition...nectar thick liquids except for water (supervise resident when drinking all water)...monitor fluid intakes..."</p> <p>On 8/19/14 at 11:14 A.M., Resident #155 was interviewed. He was observed to be sitting in a wheelchair in his room. He indicated his family member shares the room with him. He indicated he would "like to have more water." At the time, there was only one large gray covered pitcher observed in this room. This gray pitcher was observed to be placed on top of the dresser drawer unit across the room from the resident's bed. At the time, no water was observed to be at the resident's bedside, no glass and/or mug of any color. Resident #155 indicated he was to receive thickened liquids to drink. The resident's family member was interviewed at the time and indicated that "last night he (Resident #155) was over in my bed during the night asking for water."</p> <p>On 8/21/14 at 10:25 A.M., the Staff Development Coordinator provided a copy of the current patient care guide form. This form included, but was not limited to, the following: "...nectar thick</p>			

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	<p>liquids. Except water. Supervision at all times when drinking regular water..."</p> <p>The portion of the form titled "hydration" was left blank for this resident.</p> <p>On 8/22/14 at 8:15 A.M. to 2:45 P.M., there was no covered, blue thermal mug observed at the resident's bedside. The covered, blue thermal mug was observed during the time period to be across the room from the resident's bedside. The blue thermal mug was observed on top of a dresser drawer unit, of which the top of the dresser was observed to be at least 46 inches high and/or just below shoulder height of a 62 inch tall person.</p> <p>On 8/22/14 at 2:10 P.M., CNA #18 was interviewed. CNA #18 indicated residents were given fresh water once a shift, which included those residents who received thickened liquids. CNA #18 indicated resident's who received thickened water, got their water in the covered, blue thermal mugs. CNA #18 indicated the mugs should be placed within reach at the resident ' s bedside. At the time, CNA #18 indicated he was unclear as to why the resident ' s mug was up out of the resident's sight and/or reach on top of the dresser drawer cabinet between the closets.</p> <p>On 8/22/14 at 2:15 P.M., Resident #155</p>			

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	<p>was interviewed. He indicated it would be better if his water pitcher was at his bedside. He indicated he doesn't usually drink much of the thickened water because he doesn't like the taste. He indicated he does get fresh water out of the faucet in the bathroom.</p> <p>On 8/25/14 at 11:38 A.M. the DON (Director of Nursing) and ADM (Administrator) were interviewed. They indicated the following: the resident was admitted to the facility on 7/29/14. The current diet order was for nectar thick liquids except for water. The resident was to be supervised when he drank the thin water.</p> <p>On 8/25/14 at 11:56 A.M., the ADM and DON were interviewed. They indicated the resident had a speech therapy evaluation on admission and the conclusion indicated the resident should have nectar thicken liquids and with supervision may have thin water. The ADM indicated the resident was not happy with the thickened liquids and he said he just won't drink. She indicated there was another speech evaluation scheduled to be completed today. The DON and ADM indicated when the resident was in his room and was not supervised, the resident should have had thickened liquids at his bedside. The</p>						

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	<p>ADM indicated the resident was not on intake and output for fluid monitoring. She indicated the resident's fluid intakes were monitored by the meal intake forms she had provided at this time.</p> <p>At the time, the total daily intakes for the 3 meals of the day were totaled from 8/15/14 - 8/22/14. The daily fluid intake totals documented ranged from 580 cc - 1390 ccs (measurement of liquid).</p> <p>At the time, the ADM indicated the resident had difficulty with vision. She indicated he is mobile with the wheelchair and/or ambulates with his rolling walker. The ADM indicated she was aware there should be fluids readily available to the resident as well.</p> <p>On 8/25/14 at 1 P.M., the ADM provided a current copy of the facility policy and procedure for Hydration. This policy was dated 7/2012 and included but was not limited to, the following: "...Water pitchers will be provided at all bedsides...Residents with thickened liquids will follow Policy and Procedure for Thickened Liquids..."</p> <p>At the time, the ADM also provided the current policy and procedure for "Resident's on Thickened Liquids." This policy was dated 7/2012 and included,</p>				

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F000332 SS=D	<p>but was not limited to, the following: "...Blue mugs are to be filled with fresh thickened water...and placed at bedside..."</p> <p>A Speech Therapy Evaluation was completed on 8/25/14 at 2:16 P.M. and included, but was not limited to, the following: "...Recommendations:...Resident may receive thin water only following Frazier Water Protocol: thin water with no food present...Resident to receive nectar thick liquids with meals and snacks..."</p> <p>3.1-46(b)</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. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 2 medication errors out of 27 opportunities for error, resulting in a 7.4% error rate. This affected 2 of 20 residents observed</p>	F000332	<p>1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. a) On 08/25/2014, all licensed nurses caring for Resident #129 and Resident #54 were immediately instructed regarding the onset of action of rapid acting insulin. b) Resident #129 and Resident #54 are to</p>	09/25/2014

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	<p>for medication pass (Resident #1 and Resident #54), and 1 of 7 nurses and 1 QMA (Qualified Medication Aide) observed to pass medications. (Nurse #16, QMA #19)</p> <p>Findings include:</p> <p>1. During the medication pass observation, Nurse #16 was observed to administer Resident #129's insulin (Novolog 3 units subcutaneously) for a blood sugar of 201 on 8-20-2014 at 11:59 a.m..</p> <p>An observation on 8-20-2014 at 12:15 p.m., in the Lavendel Place Dining Room, indicated Resident #129 was served a 4 oz. glass of water and during an interview with Resident #129 at 12:15 p.m., he indicated he was only served some water so far.</p> <p>An observation on 8/20/14 at 12:23 p.m., indicated Resident #129 was served grape juice in a 4 ounce glass which he sipped.</p> <p>An observation on 8/20/14 at 12:30 p.m., indicated Resident #129 was served his noon meal.</p> <p>A review of Resident #129's clinical records indicated Resident #129's</p>		<p>receive a beverage and appetizer for consumption within 15 minutes of receiving a rapid acting insulin injection. c) Resident #129 and Resident #54 identified on the meal service verification sheet as being diabetic. d) Resident #129 and Resident #54 will be monitored by the staff for signs and symptoms of hypoglycemia after rapid acting insulin administration and before food is served. 2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected. a) On 09/05/2014, the number of residents identified as currently receiving rapid acting insulin totaled 13 residents. b) All 13 diabetic residents receiving rapid acting insulin will be provided a beverage and an appetizer for consumption within 15 minutes of receiving a rapid acting insulin injection. c) All diabetic residents within the facility will be identified on the meal service verification sheet for the unit on which they reside as being diabetic. d) All 13 diabetic residents who receive rapid acting insulin will be monitored for signs and symptoms of hypoglycemia after administration of rapid acting insulin and before food is served. e) The Insulin Administration</p>		

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	<p>diagnoses included but were not limited to, diabetes mellitus, hypertension, atrial fibrillation, congestive heart failure, renal failure.</p> <p>A review of Resident #129's physician orders, dated 8-11-14, indicated an order for, "...Novolog Flexpen...inject by subcutaneously (SQ) as per insulin sliding scale protocol...everyday at 8:00 am; 12:00 pm; 5:00 pm....."</p> <p>A review of Resident #129's electronic Administration Documentation History Detail Report indicated the following: -"...On 8-20-14 Novolog Flexpen 100 units/ml(milliliter) subcutaneous...3 Units given in right arm...Sugar 201 mg/dl 8-20-14 at 11:52 a...administered by Nurse #16.</p> <p>2. . During the medication pass observation, Nurse #16 was observed to administer Resident #54's insulin (Novolog 3 units subcutaneously) for a blood sugar of 240 on 8-20-2014 at 12:00 p.m. in her room.</p> <p>During an observation on 8/20/14 at 12:05 p.m., Nurse #16 pushed Resident #54 in her wheelchair to a table in the Lavendel Place Dining Room. The CNA (Certified Nursing Aide) staff provided the resident with a cup of hot tea and</p>		<p>Policy was revised on 09/05/2014 to indicate these changes (See Form #12-8). f) All nursing staff on all units instructed on the rapid acting insulin administration and need for a beverage and appetizer to be served with 15 minutes. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. a) All nursing staff will be re-educated on 09/17/2014 on diabetes mellitus, the effects of insulin, signs and symptoms of hyper/hypoglycemia, and the insulin administration policy. b) New licensed nurses will be oriented on the insulin administration. This has been added to the new licensed nurse orientation (See Forms #6 and #7). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. a) Consultant pharmacist will observe one random medication pass monthly for three months, then quarterly thereafter with the emphasis on ensuring that a beverage and appetizer are given within 15 minutes of rapid acting insulin administration. b) Unit managers or their designee on each unit will observe one med pass weekly for</p>				

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	<p>glass of water. The resident did not drink the fluids provided.</p> <p>An observation on 8/20/14 at 12:32 p.m., indicated Resident #54 was served her noon meal.</p> <p>A review of Resident #54's clinical records indicated her diagnoses included but were not limited to, diabetes mellitus, hypothyroidism, hyperlipidemia, depressive disorder, osteoporosis, nutrition deficiency, neuropathy in diabetes, senile dementia, hypertension and atrial fibrillation.</p> <p>A review of Resident #54's physician orders, dated 8-5-14, indicated an order for, "...Novolog Flexpen...inject by subcutaneously (SQ) as per insulin sliding scale protocol...everyday at 8:00 am; 12:00 pm; 5:00 pm....."</p> <p>A review of Resident #54's electronic Administration Documentation History Detail Report indicated the following: -"...On 8-20-19, 12:00 p.m., Novolog Flexpen 100 units/ml(milliliter) subcutaneous...3 Units given in left abdomen...Sugar 240 mg/dl at 8/20/14 12:00 P.M...administered by LPN#16.</p> <p>During an interview with Nurse #15 on 8/21/14 at 2:45 p.m., she indicated a</p>		four weeks, biweekly for two months, and monthly thereafter to ensure that a beverage and appetizer are served with 15 minutes of rapid acting insulin administration (See Forms #8 and #10).				

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	<p>Resident needed to eat within 15 to 30 min. of taking Sliding Scale Insulin Coverage.</p> <p>During an interview with Nurse #14, on 8/21/14 at 2:50 p.m., she indicated a Resident needed to have something to eat within 10-15 minutes of receiving Novolog Insulin.</p> <p>During an interview with the DON (Director of Nursing) on 8/21/14 at 3:00 p.m., the DON indicated a resident needed to have something to eat within 15 minutes of receiving a fast acting insulin.</p> <p>During an interview with the DON on 8/22/14 at 9:50 a.m., the DON indicated the nursing staff was re-educated on the amount of time allowed between administration of a fast acting insulin and eating. He also indicated the CNA's and dining staff were educated on the need to serve Diabetic Resident right away when they come to the dining room.</p> <p>On 8/22/14 at 9:50 a.m., the DON provided the Facility's policy. A review of the non-dated policy, titled, Insulin Administration, indicated the following, "...Onset of action-how quickly the insulin reaches the bloodstream and begins to lower blood</p>			

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F000371 SS=E	<p>glucose...Rapid-acting...Onset 10-15 minutes...."</p> <p>A review of the Nursing 2014 Drug Handbook indicated the following, "... Novolog (Insulin Aspart)...give 5 to 10 minutes before start of meal by subcutaneous injection....Because of it's rapid onset of action...."</p> <p>3.1-25(b)(9)</p> <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 their hands for the recommended length of time and after touching soiled surfaces, failed to protect clean dishes from possible contamination, and failed to protect food from possible contamination potentially affecting 76 of the 117 residents who ate their meals in the facility dining rooms.</p> <p>Findings include:</p>	F000371	<p>1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. a) Nursing and Dietary Staff who serve the 76 residents mentioned in the above citation were immediately instructed on the importance of proper hand washing and safe handling of serving dishes in order to prevent contamination. b) Nursing and Dietary Staff who serve the 76 residents were immediately instructed on the importance of protecting food from contamination by keeping the protective covers on food until</p>	09/25/2014			

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	<p>1. During an observation of the lunch meal in the Alpenrose dining room on 8/18/14 the following was observed:</p> <p>- At 11:45 a.m., an open food cart was brought from the facility kitchen to a hallway close to the dining room in the secured living unit where the service area was located for meals. The open cart contained 2 covered sheet pans of 17 assorted salads and 13 cherry crisps. The protective covers over the salads and desserts were removed while staff took the temperatures of the food. Once the temperatures were taken, the protective covers were not placed back over the salads and desserts exposing them to potential contamination. Numerous staff and residents were observed to walk through the hallway to the dining room passing the open cart of salads and desserts. The last of the salads and desserts were served from the open cart at 12:20 p.m.</p> <p>- At 12:03 p.m., Dietary #3 started to plate food for residents in the dining room. She was not observed to wash her hands prior to the start of meal service.</p> <p>- At 12:08 p.m., Dietary #3 was observed to leave the service area and open a cabinet. She immediately returned to continued dishing plates for residents in</p>		<p>the staff is ready to serve and covering the serving containers completely during the transport from the service kitchen to the assisted dining room. c) Dietary Staff who serve the 76 residents were immediately instructed on the importance of safe handling of dishes and utensils in order to prevent contamination. 2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected.</p> <p>a) On 09/05/2014 all dietary and nursing staff, who serve food in the healthcare units, were instructed to properly wash hands for recommended length of time, and after touching soiled surfaces in order to prevent contamination of food and the Policy and Procedure for Hand Hygiene was updated (See Form #13). b) On 09/05/2014 all dietary staff who serve food in the healthcare units were instructed to serve and transport food in a safe manner by keeping the protective covers on until food until the staff is ready to serve and covering the serving containers completely during the transport from the service kitchen to the assisted dining room in order to prevent contamination (See Form #14). c) On</p>				

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	<p>the dining room. She was not observed to wash her hands.</p> <p>2. During an observation of the lunch meal in the Sonnenblum dining room on 8/19/14 the following was observed:</p> <ul style="list-style-type: none"> - At 11:19 a.m., Dietary #4 was observed to lather her hands for 11 seconds before rinsing. She then was observed to remove the steam table pans of hot food from the insulated cart. - At 11:21 a.m., Dietary #4 was observed to lather her hands for 14 seconds before rinsing. She was observed to get the steam table ready for meal service by opening drawers and removing serving utensils. - At 11:40 a.m., Dietary #4 was observed to don a disposable glove, open a cooler door, and remove a slice of cheese from a plastic bag, placing it on a plate for a resident. She was not observed to wash her hands prior to donning the disposable glove and handling the slice of cheese. - At 11:43 a.m., Dietary #4 was observed to pull at her uniform top with her bare hands. She was not observed to wash her hands before resuming meal service. - At 11:44 a.m., Dietary #4 was observed 		<p>09/05/2014 all dietary staff who serve food in the healthcare units were instructed to handle dishes in a way to prevent contamination and the Policy and Procedure for Handling of Clean Dishes was updated (See Form #15). 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. a) On 09/17/2014 all dietary and nursing staff will be re-educated on proper hand washing and the importance it plays in preventing food borne illness. 1) During inservice staff will be required to display knowledge by demonstrating hand washing. 2) On 09/05/2014 all units were checked for signage on proper hand washing and it was verified signage was in place and appropriate. b) On 09/17/2014 all dietary staff will be re-educated on properly handling service ware to prevent contamination and prevent food borne illness. c) On 09/17/2014 all dietary and nursing staff will be re-educated on serving and transporting food through a common area in order to prevent contamination. d) The serving cart will be moved to a different location in Alpenrose dining room starting 9/18/14 to prevent food contamination. 4. How the corrective action(s)</p>		

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	<p>to pick up a small bowl by placing the thumb of her right hand in the center bottom of the bowl. She then was observed to dish cottage cheese into the bowl for a resident.</p> <p>- At 11:45 a.m., Dietary #4 was observed to open a drawer to obtain a spoodle (serving utensil) for the rhubarb cream. She was not observed to wash her hands before resuming meal service.</p> <p>- At 11:46 a.m., Dietary #4 was observed to pick up a small bowl by placing the thumb of her right hand in the center bottom of the bowl. She then was observed to dish cottage cheese into the bowl for a resident.</p> <p>- At 11:53 a.m., Dietary #4 was observed to lather her hands for 10 seconds before rinsing. She then resumed meal service.</p> <p>- At 12:00 p.m. Certified Nursing Assistant (CNA) #5 was observed to carry a covered plated from the service area to the assisted dining room. She then started to feed a resident her meal. She was not observed to wash her hands prior to assisting the resident with her meal.</p> <p>- At 12:01 p.m., CNA #6 was observed to lather her hands for 8 seconds prior to</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.</p> <p>a) A hand hygiene competency criterion checklist was developed (See Form # 16). 1) Compliance will be monitored by Food Supervisors who will make 5 random observations a week for four weeks for compliance, then biweekly for two months, and once a month thereafter. Food Supervisors will record observations on monthly QA Checklist (See Form #17). 2) Monitoring for proper hand washing was added to monthly Quality Assurance Checklist (See Form #17). 3) In addition to hand washing education during orientation, new staff will be required to display their knowledge of proper hand washing by demonstrating correct process of hand washing. b) Safe handling of service ware and utensils was added to daily QA Checklist in all units (See Form #18) and also to monthly supervisor QA Checklist (See Form #17). c) Covering food and serving meals in a way to ensure food safety was added to daily QA Checklist in all units (See Form #18) and also to monthly QA Checklist (See Form #17).</p>		

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	<p>rinsing. She then resumed assisting with meal service.</p> <p>- At 12:04 p.m., a bowl of rhubarb custard was brought on a meal tray from the service kitchen to the assisted dining room. The bowl had a plastic lid on top which did not completely cover all the the rhubarb custard and protect it from possible contamination.</p> <p>- At 12:05 p.m., CNA #6 was observed to lather her hands for 11 seconds prior to rinsing. She then resumed assisting with meal service.</p> <p>- At 12:06 p.m., CNA #1 was observed to lather her hands for 13 seconds before rinsing. She then started to feed a resident her meals.</p> <p>- At 12:07 p.m., CNA #6 was observed to bring a meal tray from the service kitchen to the assisted dining room. She started to feed a resident her meal by standing next to her. She was not observed to wash her hands prior to assisting the resident with her meal.</p> <p>3. During an observation of the lunch meal in the Edelweiss dining room on 8/20/14 the following was observed:</p> <p>- At 12:00 p.m., CNA #7 was observed to</p>				

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	<p>bring a resident into the dining room by pushing her wheelchair. She then was observed to touch and adjust her hair and put a clean clothing protector on the resident. She was not observed to wash her hands prior to handling the clean clothing protector.</p> <p>- At 12:04 p.m., CNA #7 was observed to rub her nose with her hand and immediately served a plate to a resident. She was not observed to wash her hands after touching her nose with her hands.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 8/25/14 at 9:30 a.m. During the interview he indicated staff were to wash their hands for 30 seconds and were to wash their hands when entering a kitchen, before putting on disposable gloves, and after touching anything soiled. He also indicated food was to be completely covered to protect it from contamination and staff were only to handle plates and bowls by the outer rim or on the underside.</p> <p>A current facility policy "Hand Hygiene", dated 9/26/13 and provided by the CDM on 8/25/14 at 11:48 a.m., indicated "...All Food Service Employees will follow proper hand washing practices to ensure the safety of food by preventing cross-contamination and prevent the</p>			

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	<p>spread of communicable disease...1) Properly wash hands...before putting on gloves:...c. Scrub hands and arms for 20 seconds; clean under fingernails; lather well beyond wrists, including exposed portions of the arms; clean under fingernails and between fingers...2) Food Service Employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with...utensils, and unwrapped single service and single-use articles and the following...a. After touching bare human body parts other than clean hands and clean, exposed portions of the arms...d. After handling soiled surfaces, equipment or utensils...g. Before touching food or food-contact surfaces...h. Before placing gloves on hands...I. After engaging in other activities that contaminate the hands...."</p> <p>A current facility policy "Procedure for Proper Hand Washing Technique", revised on 7/2/11 and provided by the Staff Development Coordinator on 8/25/14 at 2:20 p.m., indicated "...To inhibit the transmission of microorganisms from person to person within the health care facility...To remove the transient bacteria and reduce the resident bacteria on hands...It is the policy (facility name) that staff shall use</p>			

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	<p>the proper hand washing technique in the following situations: 1. before and after contact with a resident...6. Before setting up a resident's tray...7. Before and after feeding a resident...9. Before handling clean dishes...Procedure...3. Lather hand with soap...4. Rub the palms, wrists, and the back of the hands firmly with circular motions. Interlace your fingers and hands, moving back and forth. Continue this process for no less than 20 seconds...."</p> <p>A current facility policy "Transporting of Food and Utensils", dated 9/26/13 and provided by the CDM on 8/25/14 at 11:48 a.m., indicated "Dietary Staff will transport food in a manner to ensure its quality and safety..."</p> <p>4. During an observation of the lunch meal in the Sonnenblum Place Activity Room on 8-18-2014, the following was observed:</p> <p>-At 11:44 a.m., CNA #1 served a resident her drinks, touched the resident to try to awaken her and proceeded to serve 4 additional residents without performing hand hygiene or washing her hands.</p> <p>-At 11:47 a.m., CNA #1 touched another resident, moved a different resident's wheelchair and proceeded to serve additional residents their drinks without</p>			

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	<p>performing hand hygiene or washing her hands.</p> <p>-At 11:51 a.m. - 11:54 a.m., CNA #1 moved a resident's geri chair, moved another resident's geri chair and placed a clothing protector on the resident. CNA #1 adjusted another geri chair, placed a clothing protector on the resident and proceeded to serve the 3 residents their drinks without performing hand hygiene or washing her hands.</p> <p>-At 12:00 p.m., CNA #1 carried a dish of cherry crisp through the main dining room in Sonnenblum Place and through a common hallway area to the activity room with a plastic lid that did not completely cover the cherry crisp. The cherry crisp was served to a resident in the activity room.</p> <p>-At 12:03 p.m., CNA #1 carried a dish of cherry crisp through the main dining room in Sonnenblum Place and through a common hallway area with a lid that did not completely cover the cherry crisp. The cherry crisp was served to a resident seated in the activity room. CNA #1 left the activity room and returned with a bowl of mashed potatoes. The bowl of mashed potatoes was carried from the Sonnenblum Place main dining room and through the common hall to the activity</p>						

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	<p>room with a lid that did not completely cover the bowl of potatoes.</p> <p>-At 12:16 p.m., CNA #1 lathered her hands for 15 seconds and proceeded to feed a resident with her meal.</p> <p>-At 12:17 p.m., Nurse #2 washed hands for a total of 15 seconds and proceeded to assist a resident with her meal.</p> <p>5. During an observation of the lunch meal in the Edelweiss Dining Room on 8-20-2014, the following was observed:</p> <p>-At 12:13 p.m., CNA #11 put her long hair in an elastic restraint while standing in the middle of the dining room while residents were eating their meals.</p> <p>-At 12:22 p.m., CNA #10 adjusted a resident's chair, moved a dining room chair, washed her hands by lathering 15 seconds and proceeded to feed a resident in the assisted dining room in Edelweiss.</p> <p>-At 12:30 p.m., CNA #11 carried a tray with a bowl of dessert and a bowl of jello through the dining room and down a common hallway. The dessert and jello were covered with a lid that did not completely cover the food. The dessert and the jello were served to a resident who was eating at a table in the</p>						

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F000441 SS=E	<p>Edelweiss hall.</p> <p>6. During an observation of the lunch meal in the Edelweiss Dining Room on 8-21-2014, the following was observed:</p> <p>-At 12:18 p.m., CNA #10 carried a meal tray with a bowl of peaches not completely covered from the Edelweiss dining room, across the common hallway to the activity room in Edelweiss and served the peaches to a resident.</p> <p>-At 12:19 p.m., CNA #12 carried a meal tray with a bowl of mashed potatoes not completely covered from the main dining room across the common hallway to the activity room in Edelweiss and served the potatoes to a resident.</p> <p>-At 12:24 p.m., CNA #11 carried 2 spoons-uncovered from the main dining room and across the common hallway to the activity room and gave the spoons to 2 staff who were feeding the residents.</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable</p>				

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	<p>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>A. Based on observation, interview and record review the facility failed to provide adequate handwashing by the nurses for the appropriate amount of time and/or after removing disposable gloves during medication administration and wound care, for 3 of 20 residents</p>	F000441	A 1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. a) The policy for proper Handwashing/Hand Hygiene was reviewed on 9/5/14 with all nurses involved in care of the three affected residents (See	09/25/2014			

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	<p>observed during medication administration and 1 of 1 observation of wound care. (Resident #129, #82 and #123)</p> <p>B. Based on observation, interview and record review the facility failed to protect the Resident's personal clean laundry from contamination during the delivery of clean laundry to the resident's rooms, potentially affecting all the resident's who have their personal laundry done by the facility.</p> <p>Findings include:</p> <p>A. During an observation on 8/20/14 at 11:48 a.m., Nurse #16 wore disposable gloves to perform a blood sugar check for Resident #129. The Nurse removed her disposable gloves and washed her hands in the Resident's room, she lathered her hands for 10 seconds then continued to rub her hands under the running water for another 5 seconds before rinsing her hands and drying them with a paper towel.</p> <p>During an observation on 8/20/14 at 12:01 p.m., Nurse #16 wore disposable gloves to give an insulin injection to Resident # 129. The Nurse removed her disposable gloves and she used sanitizing hand gel and resumed administering</p>		<p>Form #19). b) Nursing staff, taking care of the three residents mentioned above, were instructed on when it is appropriate to use each type of hand hygiene, the adequate amount of time required for handwashing/hand hygiene, and the appropriate use of gloves during medication administration and wound care (See Form #20).</p> <p>2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected. a) The Handwashing/Hand Hygiene and PPE-Gloves policies were updated. b) The Handwashing/Hand Hygiene and PPE-Gloves policies were reviewed and implemented with all licensed nurses on all units to ensure the infection prevention for all residents on all units. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. a) All nursing staff will be re-educated on proper handwashing/hand hygiene and glove use on 9/17/14. b) New nursing staff will be oriented on the handwashing,</p>		

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	<p>medications to the other residents.</p> <p>During an observation of wound care on 8/21/14 at 9:50 a.m., Nurse #2 wore disposable gloves for wound care for a Stage II pressure ulcer on Resident #82's coccyx. When the procedure was completed and the trash was disposed of, the Nurse removed the disposable gloves and washed her hands with soap and water, she lathered her hands for 10 seconds before rinsing her hands with water and dried them with a paper towel.</p> <p>During an observation on 8/21/14 at 3:20 p.m., Nurse #14 wore disposable gloves as she administered the nebulizer treatment to Resident #123. The nurse cleaned the nebulizer mouth piece and medication cup with the disposable gloves on. The nurse removed the disposable gloves and used alcohol based hand sanitizer gel to do hand hygiene.</p> <p>During an interview on 8/25/14 at 10:15 a.m. with Nurse #15 indicated handwashing should be done for 20 seconds and she also indicated handwashing should be done before and after glove use.</p> <p>An interview on 8/25/14 at 10:50 a.m., with Nurse #14 indicated handwashing should be done before any procedure and</p>		<p>hand hygiene, and proper glove use. This has been added to the new nursing staff orientation (See Forms #6 and #7). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. Compliance will be monitored by Unit Managers or their designee doing a QA on five randomly selected nursing staff weekly for one month, then biweekly for two months, then monthly thereafter. (See Form #10 and Form #21). B 1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. The laundry staff instructed on keeping the residents' personal clean laundry covered at all times during the delivery of clean laundry in healthcare. 2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected. The Policy for The Clean Linen and Laundry Transport was created on 9/5/14 (See Form #22). The Clean Linen and Laundry Transport policy was reviewed and implemented with all of the laundry staff on 9/5/14.</p>				

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	<p>indicated the hands should be washed for the length of time it takes to sing, "Happy Birthday" or 30 seconds to 1 minute. She indicated handwashing should be done before putting on gloves and also after removing gloves. She indicated handwashing should be done if hands were visibly dirty and she further indicated hand gel could be used after removing gloves if the hands were not visibly soiled.</p> <p>An Interview on 8/25/14 at 2:20 p.m., with Nurse # 13 indicated the facility policy stated to continue the lathering procedure for no less than 20 seconds. She indicated the entire handwashing process should take 40 to 60 seconds.</p> <p>During an interview on 8/25/14 at 2:25 p.m., the DON (Director of Nursing) was queried, and he did not indicate when handwashing should be done with disposable glove use. He indicated he would provide the Facility's policy.</p> <p>On 8/25/14 at 2:20 p.m., Nurse #13 provided the Facility's Policy, titled, Procedure for Proper Hand Washing Technique, with date revised of 7/2011, the policy indicated the following, "...2. Thoroughly wet hands and apply soap. 3. Lather hand with soap. 4. Rub the palms, wrist and back of the hands firmly with</p>		<p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. a) All of the laundry staff will be inserviced on the policy for the clean linen and laundry transport on 9/10/14. b) All of the nursing staff will be inserviced on the clean linen and laundry transport policy on 9/17/14. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. The Laundry Supervisor will monitor compliance weekly for four weeks, biweekly for two months, and monthly thereafter to ensure proper clean laundry transport (See Forms #23 and #24).</p>				

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	<p>circular motions. Interlace you fingers and hands, moving back and forth. Continue this process for no less than 20 seconds...."</p> <p>On 8/25/14 at 3:45 p.m., Nurse #13 provided the Facility's Policy, titled, Personal Protective Equipment-Gloves with revised dated of August 2009, the policy indicated the following, "...Perform the appropriate hand hygiene procedure after removing gloves."</p> <p>During an interview on 8/25/14 at 3:46 p.m., Nurse #13 indicated Handwashing with soap and water should be completed after glove use and should be done if the Resident was touched during administration of medications and procedures.</p> <p>B. During an observation on 8/18/14 at 12:22 p.m., Laundry Staff #17 was pushing the clean laundry cart down the hallway of Edelweiss Place. The laundry cart was open on one side and the side cover was folded on top of the cart. The laundry cart contained the Resident's clean clothes hanging on hangers. The Laundry staff pushed the open cart passed the nurses station and dining room while the residents were eating. At 12:26 p.m., the Laundry Staff parked the laundry cart in the center of the hall and carried the</p>			

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	<p>uncovered clean hanging laundry 20 to 25 feet down the hallway to a Resident's room.</p> <p>During an observation on 8/21/14 at 11:00 a.m., the Laundry Staff #17 pushed the clean laundry cart in Sonnenblum Place, and delivered clean laundry on hangers to the resident's rooms. The laundry cart was uncovered on one side as she pushed the cart from room to room. The Laundry staff pushed the laundry cart from Sonnenblum Place to the Alpenrose Place and the laundry cart remained open on one side with clean laundry inside.</p> <p>During an observation on 8/21/14 at 11:15 a.m. the Laundry Staff #17 delivered Laundry to a Resident's room on Westenfeld. The laundry cart was open on 1 side as she pushed the cart down the hallway.</p> <p>During an observation on 8/22/14 at 11:00 a.m., the Laundry Staff #17 delivered clean laundry to the Resident's rooms on Edelweiss Place. The clean laundry was hung on hangers in the cart and the cart was open on one side as the laundry was delivered room to room.</p> <p>During an observation on 8/25/14 at 1:25 p.m., the Laundry Staff #17 was</p>			

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	<p>delivering clean folded laundry to the Resident's Rooms on Lavendel Place. She pushed the cart from room to room with 1 side of the laundry cart open.</p> <p>An interview on 8/25/14 at 1:25 p.m. with Laundry Staff #17 indicated if any of the clean laundry touched or spilled on the floor, it would need to be sent back to the laundry and re-washed. She indicated the laundry cart was to be opened on one side when at the resident's room.</p> <p>An interview on 8/25/14 at 1:50 p.m. the Department Manager of Housekeeping and Laundry indicated the clean linens and the Resident's personal laundry were to be transported to the units in covered carts. She indicated the Resident's personal laundry was to be covered and delivered to each room and the cart was to be covered when moving it from unit to unit. She also indicated the Resident's personal laundry was to be transported the same as the Facility's linens.</p> <p>On 8/25/14 at 3:20 p.m. the Administrator provided the non-dated Facility's Policy, titled, Laundry Procedures, which indicated the following, "...Transporting Linen: 1. Carts to transport clean linens and laundry to nursing areas are stored in Clean Linen Storage room and adjacent</p>			

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F000514 SS=D	<p>area. 2. Covers MUST be on carts at ALL times while transporting linen to and from nursing areas...."</p> <p>3.1-18(1) 3.1-19(g)(2)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to maintain accurate documentation in the clinical record of fluid intakes for 1 resident (Resident #129) with a fluid restriction.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #129 on 8/20/14 at 8:45 a.m., indicated the following: diagnoses included, but were not limited to, renal failure, renal</p>	F000514	<p>1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. a) The electronic medical record has been configured to reflect the accurate fluid documentation on 9/4/14 for Resident #129. b) The Daily Fluid Intake Monitoring sheet was initiated for the Resident #129 to ensure accurate documentation in the clinical record of fluid intake (See Form #2). 2. Describe how the facility reviewed all of the residents in the facility who</p>	09/25/2014			

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	<p>dialysis status, neoplasms of bladder, history of malignant neoplasm of prostate, diabetes mellitus, and unspecified nutritional deficiency.</p> <p>A physician's order for Resident #129, dated 5/20/14, indicated 1200 cc (cubic centimeters) fluid restriction. The orders also indicated to document cc's consumed on I & O (intake and output) sheet.</p> <p>A physician's order for Resident #129, dated 5/22/14, indicated to add Nepro (a renal supplement) 120 ml (milliliter) at HS (hour of sleep), increasing the fluid provided by nursing service to 600 ml in a 24 hour period.</p> <p>A physician's order for Resident #129, dated 6/9/14, indicated Polyethylene Glycol (Miralax) 17 grams mixed with 8 ounces of water, juice, soda, coffee or tea daily, increasing the fluid provided by nursing service to 840 ml in a 24 hour period.</p> <p>A physician's order for Resident #129, dated 6/12/14, indicated Prostat (protein supplement) Sugar Free 30 ml BID (twice a day), increasing the fluid provided by nursing service to 900 ml in a 24 hour period.</p> <p>Calculations indicated Resident #129</p>		<p>could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected. a) The electronic medical record has been configured to reflect the accurate fluid documentation for all residents on a fluid restriction on 9/4/14. b) The Daily Fluid Intake Monitoring sheets were implemented for all residents on a fluid restriction. c) The Meal Service Verification Sheet was updated to reflect all residents on a fluid restriction (See Form #3). 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. a) The Hydration Policy and Procedure was updated on 9/4/14 to reflect the plan for monitoring fluid intakes for residents on fluid restrictions and maintaining accurate documentation in the clinical record of fluid intake (See Form #5). b) The nursing staff will be re-inserviced on 9/17/14 on the proper monitoring for residents on fluid restriction and accurate fluid intake documentation. d) New nursing employees will be oriented on the fluid restriction documentation. This has been added to the new nursing</p>				

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	<p>would receive 1620 cc's per day from dietary and nursing.</p> <p>Review of the Administration Documentation History Detail Reports for Resident #129, dated for the month of August, 2014, indicated he received the 120 ml Nepro and the 30 ml Prostat BID as ordered.</p> <p>Review of the Medication Administration Record for Resident #129 indicated the Miralax was given in 8 ounces of fluid as ordered.</p> <p>Review of the Resident CNA (Certified Nursing Assistant) Documentation History Detail, the Administration Documentation History Detail Report and the Intake Report for Resident #129, for the month of August, 2014, indicated the following:</p> <ul style="list-style-type: none"> - On 8/1/14 the CNA Documentation History Detail indicated he consumed 480 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 720 cc's of fluid, and the Intake Report indicated he consumed 480 cc's of fluid from the CNAs and 690 cc's of fluid from nursing. - On 8/2/14 the CNA Documentation History Detail indicated he consumed 		<p>employee orientation (See Forms #6 and #7). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. a) Residents on a fluid restriction will be audited on a weekly basis by Director of Healthcare Services during the healthcare management meeting to ensure that the facility is maintaining accurate documentation in the clinical record of fluid intakes. b) Unit managers on each unit will audit residents on a fluid restriction monthly with QA Checklist (See Form #8).</p>		

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	<p>480 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 240 cc's of fluid, and the Intake Report indicated he consumed 240 cc's of fluid from the CNAs and 480 cc's of fluid from nursing.</p> <p>- On 8/3/14 the CNA Documentation History Detail indicated he consumed 840 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 720 cc's of fluid, and the Intake Report indicated he consumed 420 cc's of fluid from the CNAs and 720 cc's of fluid from nursing.</p> <p>- On 8/4/14 the CNA Documentation History Detail indicated he consumed 760 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1160 cc's of fluid, and the Intake Report indicated he consumed 880 cc's of fluid from the CNAs and 1040 cc's of fluid from nursing.</p> <p>- On 8/5/14 the CNA Documentation History Detail indicated he consumed 720 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 830 cc's of fluid, and the Intake Report indicated he consumed 720 cc's of fluid from the CNAs and 980 cc's of fluid from nursing.</p>			

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	<p>- On 8/6/14 the CNA Documentation History Detail indicated he consumed 1240 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1200 cc's of fluid, and the Intake Report indicated he consumed 340 cc's of fluid from the CNAs and 1290 cc's of fluid from nursing.</p> <p>- On 8/7/14 the CNA Documentation History Detail indicated he consumed 1200 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 880 cc's of fluid, and the Intake Report indicated he consumed 720 cc's of fluid from the CNAs and 1000 cc's of fluid from nursing.</p> <p>- On 8/8/14 the CNA Documentation History Detail indicated he consumed 420 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1170 cc's of fluid, and the Intake Report indicated he consumed 600 cc's of fluid from the CNAs and 1110 cc's of fluid from nursing.</p> <p>- On 8/9/14 the CNA Documentation History Detail indicated he consumed 480 cc's of fluid, the Administration</p>			

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	<p>Documentation History Detail Report indicated he consumed 940 cc's of fluid, and the Intake Report indicated he consumed 840 cc's of fluid from the CNAs and 1060 cc's of fluid from nursing.</p> <p>- On 8/10/14 the CNA Documentation History Detail indicated he consumed 840 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1080 cc's of fluid, and the Intake Report indicated he consumed 420 cc's of fluid from the CNAs and 1020 cc's of fluid from nursing.</p> <p>- On 8/11/14 the CNA Documentation History Detail indicated he consumed 960 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1240 cc's of fluid, and the Intake Report indicated he consumed 1020 cc's of fluid from the CNAs and 1060 cc's of fluid from nursing.</p> <p>- On 8/13/14 the CNA Documentation History Detail indicated he consumed 960 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1200 cc's of fluid, and the Intake Report indicated he consumed 480 cc's of fluid from the</p>			

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	<p>CNAs and 990 cc's of fluid from nursing.</p> <p>- On 8/14/14 the CNA Documentation History Detail indicated he consumed 720 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 800 cc's of fluid, and the Intake Report indicated he consumed 360 cc's of fluid from the CNAs and 920 cc's of fluid from nursing.</p> <p>- On 8/15/14 the CNA Documentation History Detail indicated he consumed 760 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1200 cc's of fluid, and the Intake Report indicated he consumed 1480 cc's of fluid from the CNAs and 1020 cc's of fluid from nursing.</p> <p>- On 8/16/14 the CNA Documentation History Detail indicated he consumed 720 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 900 cc's of fluid, and the Intake Report indicated he did not consume any fluids from the CNAs and consumed 1200 cc's of fluid from nursing.</p> <p>- On 8/17/14 the CNA Documentation History Detail indicated he consumed 720 cc's of fluid, the Administration</p>			

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	<p>Documentation History Detail Report indicated he consumed 1018 cc's of fluid, and the Intake Report indicated he consumed 720 cc's of fluids from the CNAs and 940 cc's of fluid from nursing.</p> <p>- On 8/18/14 the CNA Documentation History Detail indicated he consumed 600 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1290 cc's of fluid, and the Intake Report indicated he consumed 480 cc's of fluids from the CNAs and 1050 cc's of fluid from nursing.</p> <p>- On 8/19/14 the CNA Documentation History Detail indicated he consumed 360 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 690 cc's of fluid, and the Intake Report indicated he consumed 60 cc's of fluid from the CNAs and 840 cc's of fluid from nursing.</p> <p>- On 8/20/14 the CNA Documentation History Detail indicated he consumed 840 cc's of fluid, the Administration Documentation History Detail Report indicated he consumed 1170 cc's of fluid, and the Intake Report indicated he consumed 500 cc's of fluid from the CNAs and 1170 cc's of fluid from nursing.</p>				

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R000000	<p>The Administrator in Training was interviewed on 8/21/14 at 3:55 p.m. During the interview she indicated all fluids were recorded on the intake record. She also indicated the CNAs recorded fluid intakes for meals and nursing staff recorded fluid intakes during medication pass and snacks.</p> <p>The Administrator in Training and the Director of Nursing were interviewed on 8/22/14 at 10:00 a.m. During the interview they indicated there was no easy way to determine the total amount of fluids Resident #129 received each day at mealtime, with medication pass, with supplements, and during snack time.</p> <p>A current facility policy "Charting and Documentation", revised on April, 2008 and provided by the Administrator in Training on 8/22/14 at 2:14 p.m., indicated "...All observations, medications administered, services performed, etc., must be documented in the resident's clinical records..."</p> <p>3.1-50(a)(1)(2)</p> <p>Swiss Village was found to be in compliance with 410 IAC 16.2-5 in</p>	R000000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	regards to the State Licensure Survey.				