

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155434	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2011
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CONNERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 N GRAND AVE CONNERSVILLE, IN47331
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 28, 29, 30, December 1 & 3, 2011</p> <p>Facility number: 000319 Provider number: 155434 AIM number: 100286530</p> <p>Survey team: Leslie Parrett RN TC Sharon Lasher RN Angel Tomlinson RN Barbara Gray RN</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 5 Medicaid: 20 Other: 7 Total: 32</p> <p>Sample: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/7/11</p>	F0000		

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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F0281 SS=D	<p>Cathy Emswiler RN</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to follow the 5 rights of medication administration, in that the resident was not administered a physicians ordered medication and was administered the wrong medication, for 1 of 8 residents observed for medication administration. (Resident #23) (LPN # 1)</p> <p>Findings include:</p> <p>On 11/30/11 at 8:25 A.M., LPN #1 was observed administering medications to Resident #23.</p> <p>Resident #23's record was reviewed on 11/30/11 at 9:15 A.M.</p> <p>A physician's order for Resident #23 dated 9/7/11, indicated the following: 1.) Discontinue Zocor. 2.) Lipitor 20 milligram (mg) tablet by mouth everyday, for a diagnosis of hyperlipidemia [high cholesterol].</p> <p>A re-admission physician's order for Resident #23 dated 11/17/11,</p>	F0281	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. Hickory Creek at Connorsville desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective on 12/23/11. F281 It is the policy of this facility to meet professional standards of quality, including following the 5 rights of medication administration. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #23's medications have been reviewed by the DON. Resident #23 is receiving all medications currently ordered by the physician. The Pharmacy was contacted on 12/7/11 by the Administrator to file a quality issue concern. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All resident</p>	12/23/2011	

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	<p>indicated the following: Lipitor 20 mg by mouth every A.M., for a diagnosis of hyperlipidemia.</p> <p>An interview with LPN #1 on 11/30/11 at 9:31 A.M., indicated Resident #23's had an order to receive Lipitor 20 mg every A.M., on her medication record. LPN #1 indicated she did not administer Resident #23's ordered Lipitor 20 mg medication during her morning medication pass. At that time, LPN #1 surveyed her medication cart and indicated Lipitor was not available for Resident #23.</p> <p>On 11/30/11 at 3:00 P.M., LPN #1 indicated pharmacy had delivered Resident #23's Lipitor medication after they were notified that day Resident #23 had no Lipitor available.</p> <p>Resident #23's November 2011 medication record was documented that Resident #23 had received Zocor 40 mg daily at 7:00 P.M., from November 2, 2011 to November 13, 2011. The medication record for November 1, 2011 and November 14, 2011 was initialed and circled. The circle indicating the resident was unavailable or refused the medication. The Zocor was documented on the November 2011 medication record as discontinued on 11/17/11.</p>		<p>medication orders have been audited to ensure all medications are in fact in the building. There were not other residents affected. In the future, if the DON finds that any medication is not being given and documented as per the physician's orders, she will correct the issue immediately and notify the physician and pharmacy of any discrepancy noted. Once the resident is taken care of, the DON will review the facility's policy and procedure for medication administration with the nurse involved. In addition, the DON will render progressive disciplinary action for continued noncompliance. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nurses who signed the Medication Administration record indicating that the med was being given when resident #23's Lipitor was not available, have been counseled in writing. All nurses have been in-serviced on 12/21/11 regarding proper medication administration emphasizing the "5 rights" of a medication pass. To ensure ongoing compliance, the DON/ Designee will check all medication orders against the pharmacy delivery manifest after each admission / re-admission . The DON will also check and reconcile the physician orders against the medications in the</p>		

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	<p>Resident #23's November 2011 medication record was documented that Resident #23 had received Lipitor 20 mg daily at 8:00 A.M., from November 1, 2011 to November 14, 2011 and from November 18, 2011 to November 29, 2011.</p> <p>An interview with the Director of Nursing (DoN) on 12/1/11 at 2:51 P.M., indicated the last fill date from pharmacy for Resident #23 was 11/7/11. The DoN indicated the pharmacy brought a 30 day supply of Zocor on 11/7/11, instead of the ordered Lipitor. The DoN indicated Resident #23 did not have an order for Zocor. The DoN indicated Resident #23 could not have received her physician's ordered Lipitor from November 8, 2011 to November 14, 2011 because it was not available. The DoN indicated Zocor was documented as given on Resident #23's medication record from November 2, 2011 to November 13, 2011 and Lipitor was documented as given on Resident #23's medication record from November 1, 2011 to November 14, 2011. The DoN indicated Resident #23 was hospitalized from 11/14/11 to 11/17/11. The DoN indicated Resident #23 returned from the</p>		<p>medication cart for each resident on a weekly basis. Any identified issues or concerns will be addressed as indicated in question #2.4. 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 into place. The pharmacy's quality assurance report regarding the medication delivery concerns will be reviewed with the QA committee at the next monthly meeting when received. In addition, the DON will track and report any issues with medication deliveries / medication administration to the QA committee on a monthly basis for further recommendations for process improvement. This will continue on an ongoing basis. Date of Compliance: 12/23/11</p>	

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	<p>hospital on 11/17/11 with an order for Lipitor 20 mg by mouth every A.M. The DoN indicated the Lipitor was never delivered from pharmacy after Resident #23 returned from the hospital. The DoN indicated Resident #23 did not receive her ordered Lipitor from November 18, 2011 to November 30, 2011 because it was not available. The DoN indicated the medication record was documented that Resident #23 received her physician's ordered Lipitor from November 18, 2011 to November 29, 2011. The DoN indicated she did not know why the Zocor order came back on the November 2011 re-write medication record and why pharmacy sent Zocor instead of Lipitor. The DoN indicated Resident #23 received her physician's ordered Lipitor on November 30, 2011 after it was delivered from pharmacy and Resident #23 had went 19 days in the facility without the medication.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated the following: The "five rights" of drug administration - Nurses are legally responsible for applying and ensuring the "five rights" of drug administration. To help achieve these goals, use the following strategies: 1.) Right patient. 2.) Right drug. 3.) Right dosage. 4.)</p>			

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	<p>Right time. 5.) Right route... Additional nursing responsibilities: Of course, nursing responsibilities don't stop with these five rights. Documentation, monitoring, and patient teaching are also crucial....</p> <p>The most recent Medication policy and procedure provided by the Director of Nursing on 12/5/11 at 12:32 P.M., indicated the following: Administration of medications - ... 2.) Read the label 3 times before administering the medication. First, when comparing the label with the MAR, second when pulling up the medication, and third, when preparing to administer the medication to the resident... 5.) Record the medication given on the medication sheet....</p> <p>3.1-35(g)(1)</p>				

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to administer a physician's ordered medication and administered the wrong medication, for 1 of 8 resident's observed for medication administration. (Resident #23) (LPN #1)</p> <p>Findings include:</p> <p>On 11/30/11 at 8:25 A.M., LPN #1 was observed administering medications to Resident #23.</p> <p>A physician's order for Resident #23 dated 9/7/11, indicated the following: 1.) Discontinue Zocor. 2.) Lipitor 20 milligram (mg) tablet by mouth everyday, for a diagnosis of hyperlipidemia [high cholesterol].</p> <p>A re-admission physician's order for Resident #23 dated 11/17/11, indicated the following: Lipitor 20 mg by mouth every A.M., for a diagnosis of hyperlipidemia.</p> <p>An interview with LPN #1 on 11/30/11 at 9:31 A.M., indicated Resident #23's had an order to receive Lipitor 20 mg</p>	F0282	<p>F 282It is the policy of this facility to provide or arrange services by qualified persons, including appropriate administration of residents' medications.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident # 23's medications have been reviewed by the DON. Resident #23 is receiving all medications currently ordered by the physician.The pharmacy was contacted on 12/7/11 by the Administrator to file a quality issue concern.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All resident medication orders have been audited to ensure all medications are in fact in the building. There were no other residents affected.In the future, if the DON finds that any medication is not being given and documented as per the physician's orders, she will correct the issue immediately and notify the physician and pharmacy of any discrepancy noted. Once the resident is taken care of, the DON will review the facility's policy and procedure for medication administration with the nurses involved. In addition, the</p>	12/23/2011	

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	<p>every A.M., on her medication record. LPN #1 indicated she did not administer Resident #23's ordered Lipitor 20 mg medication during her morning medication pass. At that time, LPN #1 surveyed her medication cart and indicated Lipitor was not available for Resident #23.</p> <p>On 11/30/11 at 3:00 P.M., LPN #1 indicated pharmacy had delivered Resident #23's Lipitor medication after they were notified that day Resident #23 had no Lipitor available.</p> <p>Resident #23's November 2011 medication record was documented that Resident #23 had received Zocor 40 mg daily at 7:00 P.M., from November 2, 2011 to November 13, 2011. The medication record for November 1, 2011 and November 14, 2011 was initialed and circled. The circle indicating the resident was unavailable or refused the medication. The Zocor was documented on the November 2011 medication record as discontinued on 11/17/11.</p> <p>Resident #23's November 2011 medication record was documented that Resident #23 had received Lipitor 20 mg daily at 8:00 A.M., from November 1, 2011 to November 14,</p>		<p>DON will render progressive disciplinary action for continued noncompliance.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.All nurses who signed the Medication Administration Record indicating that the med was being given when resident #23's Lipitor was not available, have been counseled in writing. All nurses have been in-serviced on 12/21/11 regarding proper medication administration emphasizing the "5 rights" of a medication pass.To ensure ongoing compliance, the DON/Designee will check all medication orders against the pharmacy delivery manifest after each admission / re-admission. The DON will also check and reconcile the physician orders against the medications in the medication cart for each resident on a weekly basis. Any identified issues or concerns will be addressed as indicated in question #2.4. 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 into place.The pharmacy's quality assurance report regarding the medication delivery concerns will be reviewed with the facility's QA committee at the next monthly meeting when received. In addition, the DON will track</p>		

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	<p>2011 and from November 18, 2011 to November 29, 2011.</p> <p>An interview with the Director of Nursing (DoN) on 12/1/11 at 2:51 P.M., indicated the last fill date from pharmacy for Resident #23 was 11/7/11. The DoN indicated the pharmacy brought a 30 day supply of Zocor on 11/7/11, instead of the ordered Lipitor. The DoN indicated Resident #23 did not have an order for Zocor. The DoN indicated Resident #23 could not have received her physician's ordered Lipitor from November 8, 2011 to November 14, 2011 because it was not available. The DoN indicated Zocor was documented as given on Resident #23's medication record from November 2, 2011 to November 13, 2011 and Lipitor was documented as given on Resident #23's medication record from November 1, 2011 to November 14, 2011. The DoN indicated Resident #23 was hospitalized from 11/14/11 to 11/17/11. The DoN indicated Resident #23 returned from the hospital on 11/17/11 with an order for Lipitor 20 mg by mouth every A.M. The DoN indicated the Lipitor was never delivered from pharmacy after Resident #23 returned from the hospital. The DoN indicated Resident</p>		<p>and report any issues with medicatin deliveries / medication administration to the QA committee on a monthly basis for further recommendations for process improvement. This will continue on an ongoing basis.Date of Compliance: 12/23/11</p>	

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	<p>#23 did not receive her ordered Lipitor from November 18, 2011 to November 30, 2011 because it was not available. The DoN indicated the medication record was documented that Resident #23 received her physician's ordered Lipitor from November 18, 2011 to November 29, 2011. The DoN indicated she did not know why the Zocor order came back on the November 2011 re-write medication record and why pharmacy sent Zocor instead of Lipitor. The DoN indicated Resident #23 received her physician's ordered Lipitor on November 30, 2011 after it was delivered from pharmacy and Resident #23 had went 19 days in the facility without the medication.</p> <p>The most recent Medication policy and procedure provided by the Director of Nursing on 12/5/11 at 12:32 P.M., indicated the following: Purpose - Designated staff members will give medications only as ordered by the physician....</p> <p>3.1-35(g)(2)</p>			

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, interview, and record review, the facility's pharmacy failed to deliver a physicians ordered medication and delivered a medication that was not ordered for 1 of 8 residents observed for medication administration. (Resident #23) (LPN #1)</p> <p>Findings include:</p> <p>On 11/30/11 at 8:25 A.M., LPN #1 was observed administering medications to Resident #23.</p>	F0425	F 425It is the policy of this facility to provide pharmacy services, including delivery of medications as ordered by the physician.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #23's medications have been reviewed by the DON. Resident #23 is receiving all medications currently ordered by the physician. The Pharmacy was contacted on 12/7/11 by the Administrator to file a quality issue concern.2. How other residents haveing the potential to	12/23/2011

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	<p>A physician's order for Resident #23 dated 9/7/11, indicated the following: 1.) Discontinue Zocor. 2.) Lipitor 20 milligram (mg) tablet by mouth everyday, for a diagnosis of hyperlipidemia [high cholesterol].</p> <p>A re-admission physician's order for Resident #23 dated 11/17/11, indicated the following: Lipitor 20 mg by mouth every A.M., for a diagnosis of hyperlipidemia.</p> <p>An interview with LPN #1 on 11/30/11 at 9:31 A.M., indicated Resident #23's had an order to receive Lipitor 20 mg every A.M., on her medication record. LPN #1 indicated she did not administer Resident #23's ordered Lipitor 20 mg medication during her morning medication pass. At that time, LPN #1 surveyed her medication cart and indicated Lipitor was not available for Resident #23.</p> <p>On 11/30/11 at 3:00 P.M., LPN #1 indicated pharmacy had delivered Resident #23's Lipitor medication after they were notified that day Resident #23 had no Lipitor available.</p> <p>Resident #23's November 2011 medication record was documented</p>		<p>be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All resident medication orders have been audited to ensure all medications are in fact in the building. There were no other residents affected. In the future, if the DON finds that any medication is not being given and documented as per the physician's orders, she will correct the issue immediately and notify the physician and pharmacist of any discrepancy noted. Once the resident is taken care of, the DON will review the facility's policy and procedure for medication administration with the nurses involved. In addition, the DON will render progressive disciplinary action for continued noncompliance. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nurses who signed the Medication Administration Record indicating that the med was being given when resident #23's Lipitor was not available, have been counseled in writing. All nurses have been in-serviced on 12/21/11 regarding proper medication administration emphasizing the "5 rights" of a medication pass. To ensure ongoing compliance, the DON / Designee will check all medication orders against the pharmacy delivery manifest after</p>		

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	<p>that Resident #23 had received Zocor 40 mg daily at 7:00 P.M., from November 2, 2011 to November 13, 2011. The medication record for November 1, 2011 and November 14, 2011 was initialed and circled. The circle indicating the resident was unavailable or refused the medication. The Zocor was documented on the November 2011 medication record as discontinued on 11/17/11.</p> <p>Resident #23's November 2011 medication record was documented that Resident #23 had received Lipitor 20 mg daily at 8:00 A.M., from November 1, 2011 to November 14, 2011 and from November 18, 2011 to November 29, 2011.</p> <p>An interview with the Director of Nursing (DoN) on 12/1/11 at 2:51 P.M., indicated the last fill date from pharmacy for Resident #23 was 11/7/11. The DoN indicated the pharmacy brought a 30 day supply of Zocor on 11/7/11, instead of the ordered Lipitor. The DoN indicated Resident #23 did not have an order for Zocor. The DoN indicated Resident #23 could not have received her physician's ordered Lipitor from November 8, 2011 to November 14, 2011 because it was not available. The DoN indicated Zocor was</p>		<p>each admission / re-admission. The DON will also check and reconcile the physician orders against the medications in the medication cart for each residen of a weekly basis. Any identified issues or concerns will be addressed as indicated in question #2.4. How the corrective action(s) will be monitored to ensure the deficient practice will ot recur, i.e., what quality assurance program will be put into place.The pharmacy's quality assurance report regarding the medication delivery concerns will be reviewed with the facility's QA committee at the next onthly meeting when received. In additon, the DON will track and report any issues with the medication deliveries / medication administration to the QA committee on a monthly basis for further recommendations for process improvement. This will continue on an ongoing bassis.Date of Compliance: 12/23/11</p>		

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	<p>documented as given on Resident #23's medication record from November 2, 2011 to November 13, 2011 and Lipitor was documented as given on Resident #23's medication record from November 1, 2011 to November 14, 2011. The DoN indicated Resident #23 was hospitalized from 11/14/11 to 11/17/11. The DoN indicated Resident #23 returned from the hospital on 11/17/11 with an order for Lipitor 20 mg by mouth every A.M. The DoN indicated the Lipitor was never delivered from pharmacy after Resident #23 returned from the hospital. The DoN indicated Resident #23 did not receive her ordered Lipitor from November 18, 2011 to November 30, 2011 because it was not available. The DoN indicated the medication record was documented that Resident #23 received her physician's ordered Lipitor from November 18, 2011 to November 29, 2011. The DoN indicated Resident #23 received her physician's ordered Lipitor on November 30, 2011 after it was delivered from pharmacy and Resident #23 had went 19 days in the facility without the medication.</p> <p>An interview with the DoN on 12/5/11 at 12:45 P.M., indicated the nurse should do an audit to verify</p>			

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	<p>medications needed were delivered. If medications were not delivered, the nurse should contact pharmacy as to what medications were not received and what medications still needed to be delivered.</p> <p>3.1-25(a)</p>				

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to provide perineal care in a manner to prevent potential infection for 1 of 1 residents observed for perineal care and 2 of 2 observations. (Resident #30)</p>	F0441	F441It is the policy of this facility to establish and maintain an Infection Control Program and services, including provision of perineal care in a manner to prevent potential infection.1.	12/23/2011

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	<p>Findings include:</p> <p>Resident #30's record was reviewed on 11/30/11 at 10:07 AM. Diagnoses included but were not limited to congestive heart failure and renal failure.</p> <p>Resident #30's quarterly Minimum Data Set assessment dated 10/13/11, indicated the following: Resident #30 did not walk, she required total dependence of 2 person for bed mobility and transfers, she required extensive assistance of 1 person for toileting, and she was frequently incontinent.</p> <p>On 11/30/11 at 1:48 P.M., Resident #30 was observed receiving perineal care in her bed by CNA #2 and CNA #3. Resident #30's brief was lowered and wet with urine. CNA #2 washed and rinsed Resident #30's front perineal area using an upward motion. CNA #3 placed some Zinc Oxide barrier cream on CNA #2's gloved hand. CNA #2 placed the Zinc Oxide barrier cream in Resident #30's abdomen fold and inner thighs, wearing the same gloves she used for washing. CNA #2 changed gloves after placing the Zinc Oxide barrier cream. Resident #30 was placed on her right side and her soiled brief was removed. A clean brief was placed without washing Resident #30's buttock.</p> <p>An interview with CNA #2 on 11/30/11 at 1:57 P.M., indicated she washed and rinsed Resident #30's front perineal area using an upward motion. CNA #2 indicated she changed gloves after placing the Zinc Oxide barrier cream on Resident #30's abdomen fold and thighs. CNA #2 indicated she had not cleaned Resident #30's buttock.</p> <p>On 12/1/11 at 1:11 P.M., Resident #30 was</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?CNA #2, #3, #4, & #5 were re-educated on 12/21/11 regarding proper peri care and infection control procedures.All CNA's received in-service training on 12/21/11 regarding proper peri care and infection control procedures.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.There were no other residents identified as being affected by this practice; however, if the DON observes an issue with perineal care, she will stop the process at the time of her observation and re-train the staff involved in the proper procedure. Once that is done, she will render progressive discipline for instances of continued noncompliance.3. What measures will be pu into place or what systemic changes will be made to ensure that the deficient practice does not recur? All CNA's on staff will be observed by DON or RN designee performing peri care to ensure proficiency with peri care and infection control procedures. DON will "check off" proficiency with each observation.As a means of on-going compliance, the DON / RN Designee will observe peri care/ infection control procedures daily each</p>		

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	<p>observed receiving perineal care in her bed by CNA #4 and CNA #5. Resident #30's brief was lowered and wet with urine. CNA #4 washed Resident #30's front perineal area in a downward motion beginning with her right inner thigh, then the center, then the left inner thigh, and then back to her center. Resident #30 was placed on her right side. CNA #4 washed Resident #30's inner buttock area in a downward motion. CNA #4 placed the soiled towel on Resident #30's oxygen concentrator. CNA #4 placed the 2 soiled rags on top of Resident #30's bath basket that contained Gold Bond, bath soap, and other bath items.</p> <p>An interview with CNA #4 on 12/1/11 at 1:20 P.M., indicated she was "just laying the rags and towel down". CNA #4 indicated she had washed Resident #30's inner buttock downward and should have washed upward.</p> <p>The most recent Perineal Hygiene policy and procedure provided by the Director of Nursing on 12/1/11 at 8:27 A.M., indicated the following: Procedure - ... 5.) Wash perineal area with soap and water, using disposable wipes if drainage is present. Wipe front to back and discard wipe after each stroke.</p> <p>3.1-18(l)</p>		<p>shift during each tour of duty. The daily observations will be documented and reviewed by the Administrator. Any identified issues with performance of the procedure will be addressed as indicated in question #2.4. 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 into place. The DON will present the results of her peri care/ infection control observations to the QA Committee monthly until she can report 100% compliance from all CNA staff. Once that is achieved, the QA Committee may decide to stop the documented observations, but the DON / Designee will continue random observations of each shift at least monthly for the next 90 days after that, unless directed differently by the QA Committee. Date of Compliance: 12/23/11</p>		