

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2012
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NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaint number IN00109199.</p> <p>Complaint Number IN00109199 substantiated, Federal/State deficiencies related to the allegations are cited at F-157.</p> <p>Survey Dates: June 11, 12, 13, 14, 15, 18, &amp; 19, 2012</p> <p>Facility Number: 000126 Provider Number: 155221 AIM Number: 100266400</p> <p>Survey Team: Mary Weyls RN TC Laura Brashear RN Teresa Buske RN Debra Skinner RN</p> <p>Census Bed Type: SNF/NF: 70 Residential: 29 Total 99</p> <p>Census Payor Type: Medicare: 11 Medicaid: 33 Other: 55</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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	<p>Total: 99</p> <p>Residential Sample: 5</p> <p>These Deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/25/12 Cathy Emswiller RN</p>						

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of a change in condition for 2 of 19 residents in the stage 2 sample in that 1. Resident A's fluid intake decreased</p>	F0157	<b>F 157 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident A is no longer at our facility. Resident</b>	07/19/2012			

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	<p>significantly three days prior to hospitalization, and the physician was not notified until the third day of the decrease intake, when the family ask that the resident be hospitalized. 2. Resident B had a physician's order for a urinalysis with a culture and sensitivity, and staff were unable to obtain a urine, and failed to notify the physician until three days later.</p> <p>Findings include:</p> <p>During review of resident A's clinical record, on 6/14/12 2:57 p.m. an admission date was noted of 4/24/12.</p> <p>Diagnoses were noted of, but not limited to, CHF [Congestive Heart Failure), Diabetes Mellitus, Osteoarthritis, Polymyalgia.. History of heart attack, Cardiomyopathy, Hypertension, Hypothyroidism.</p> <p>A nurses note dated 5/24/12 at 2:30 p.m. indicated the physician ordered (Celexa (antidepressant) from 10 mg [milligram] every day to 20 mg every day. Start Lamictal (Anticonvulsant/off label use Mood stabilizer) 100 mg one everyday. Assess pain every 4 hours while awake, then dose whenever necessary with Vicodin accordingly. Obtain urine for U/A</p>		<p><b>B is now clear from VRE and no longer on isolation 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 residents have the potential to be affected by this deficient practice. · Nurses will be re-educated on current policies related to the importance of recognizing a Change of Condition, the timely and appropriate reporting and its role in quality patient care. What measures will be put into place or what systemic changes will be made to ensure that the deficient does not recur: · Initiate the LCS Hydration Standard Protocols to ensure appropriate monitoring; documenting, reporting of any significant changes in fluid intake to physician and auditing tools are in place.· Fluid intake and new physician's orders will be reviewed by the Quality Assurance Clinical Inter Discipline Team (QA-IDT) following the Stand-Up meeting. This meeting occurs daily Monday through Friday. Fluid intake and New physician orders are to be checked daily by unit nurse and concerns reported to the on call nurse supervisor. · Pertinent</b></p>				

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	<p>/C&amp;S (urinalysis/culture and sensitivity) due to confusion.</p> <p>A nurses note dated 5/26/12 at 12:15 a.m., indicated "Res [resident] daughter came into facility inquired of Res [resident] status was reported to this nurse at change of shift Res [resident] had not voided since UA [urinalysis] C&amp;S [culture and sensitivity] obtained et [and] UA showed Bacteria in moderate amount. The DTR [daughter] then went down to Res [resident] room et [and] CNA went to [check] on Res [resident] found Dtr was st [straight] cathing Res [resident]. obtained 200 cc out cloudy foul smelling amber urine. This nurse immediately called on call supervisor .... The dtr then came to nursing station et [and] stated she thought her mother was becoming toxic et [and] shutting down systems and wanted her sent to ER [emergency room] attempted to call [Physician] and no return call at this time.</p> <p>A facsimile was noted, dated 5/26/12 at 12:30 a.m., indicating the resident had not voided in a 24 hour period. urinalysis showed bacteria in the resident's urine Res [resident] easily aroused alert X (times) 2 (two) T (temperature) 98.2 P (pulse) 76 R (respirations) 20 B/P (blood pressure)</p>		<p><b>findings will be discussed: an IDT note will be made in progress note with the appropriate recommendations, resident's physician notified of any significant changes in fluid intake and the reason for the change will be investigated with follow-up at next QA-IDT meeting. · Risk review for hydration will be completed for residents identified to be at risk with hydration concerns (see form).· New physician lab orders will be reviewed for timely compliance at the QA-IDT meeting.· Implement Early Warning Tool to assist C N A's and nursing staff in capturing Change of Condition in residents.· Morning QA meeting notes, tool revised to include AM and PM Nurse responsibility with a place for initials and date resolved.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The Quality Assurance Clinical Inter Discipline Team (QA-IDT) will audit compliance with physician notification of a change in condition requirement. · Audit of the number unresolved physician contacts and update of the progress of staff education will be communicated to the full QA Committee at the next</b></p>		

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	<p>150/86 O2 (oxygen) @ (at) 3 L (liters) per N/C [nasal canula] NEB [nebulizer] tx [treatment] cont [continue] to refuse, Abd [abdomen] soft non tender DTR [daughter] came in et [and] assessed res [resident] et [and] requested Res [resident] be sent to union ER [emergency room] for eval [evaluation] et [and] TX [treatment] on call supervisor notified res [resident] sent to union ER [emergency room] for eval [evaluation and treatment].</p> <p>A nurses note dated 5/26/12 at 12:30 a.m. documented "sending res [resident] out per family request Dr... notified. 0045 [ambulance] her to transport res [resident] to ER [emergency room] for eval [evaluation] and tx [treatment].</p> <p>A hospital report titled "Final Medical Report" and dated 6/2/12, indicated a diagnosis of, but not limited to, Dehydration.</p> <p>Review of the facility forms titled "Food Consumption Sheet", documentation indicated on 5/22/12 the resident's fluid consumption for Breakfast, lunch and supper was 320 ml (milliliters). On 5/23/12, 75 ml. (milliliters), 5/24/12, 30 ml., on 5/25/12 60 ml.</p>		<p><b>scheduled meeting which is July 17, 2012 and then quarterly for one year. · Continuation of reporting will be dependent on audit results and the resolution of the deficient practice.Completion Date: July19, 2012</b></p>				

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	<p>During interview, on 6/19/12 at 10:17 a.m. of the ADON (Assistant Director of Nursing), the ADON indicated the only documentation of the resident's intake was on the food consumption records. The ADON indicated documentation was lacking that the physician had been notified of the resident's decreased fluid intake.</p> <p>During Interview of RN #7 on 6/19/12 at 1:05 p.m., the RN indicated she was the day nurse that worked the unit where Resident A had resided. The RN Indicated she did notice the resident's intake decreasing the past few days prior to hospitalization, but was not aware of the physician being notified of the decreased intake.</p> <p>2. Resident B's clinical record was reviewed on 06/19/12 at 12:12 p.m. Documentation indicated Resident #B had been admitted with diagnoses which included, but were not limited to, IDDM (insulin dependent diabetes mellitus), history of UTI's (urinary tract infections), COPD (chronic obstructive pulmonary disease), stroke, HTN (hypertension), GERD (gastroesophageal reflux disease), coronary artery disease, and history of pneumonia.</p>				

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	<p>The most recent Quarterly Nursing Assessment dated 04/04/12, indicated the resident was totally incontinent due to a history of CVA (cerebral vascular accident), was aphasic, and was a Hospice patient.</p> <p>A Quarterly assessment dated 02/29/12, indicated the Resident was totally dependent for all ADL's (activities of daily living) and incontinent of both bowel/bladder with no potential for training.</p> <p>A Significant change assessment dated 04/04/12 indicated the same regarding ADL's and incontinence.</p> <p>A plan of care identifying a problem dated 02/27/12, of Urinary/bowel incontinence due to history of CVA, indicated the resident was unaware of urinary/bowel incontinence.</p> <p>A problem identifying a UTI (urinary tract infection) with VRE (Vancomycin Resistant Enterococcus) was dated on 06/12/12, with intervention of Ampicillin 500 mg (milligrams) po (by mouth) bid (2 times daily) ... x (times) 10 days.</p> <p>A telephone order dated 06/01/12 at 3:30 p.m., indicated "Received at</p>			

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	<p>Hospice office 05/29/12: Do ...U/A (urinalysis) - C &amp; S (culture and sensitivity)". This order had been written by a Hospice nurse.</p> <p>A telephone order dated 06/04/12 at 3:25 p.m., indicated "Clarification order of 06/01/12. Do ...U/A - C &amp; S. May st.(straight) cath due to incontinence". This order had been written by a Hospice nurse.</p> <p>A nurse's note dated 06/12/12 at 10:40 a.m., indicated an order had been received for Ampicillin 500 mg (milligrams) two times daily for 10 days for VRE (Vancomycin Resistant Enterococcus) with Hospice having been notified of the new order.</p> <p>No documentation was found in the clinical record to indicate the facility had difficulty obtaining a urine specimen for testing from 06/01/12 to 06/04/12, or that the physician had been made aware of staff's difficulty obtaining a specimen from the totally incontinent resident.</p> <p>During interview on 06/19/12 at 2 p.m., the ADON indicated staff had difficulty obtaining a urine specimen from the resident in the 3 day interval between 06/01 and 06/04/12, when the order for the straight cath was</p>				

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	<p>obtained, with no additional documentation provided to indicate the resident's physician had been aware of the need for st. cath order until 06/04/12.</p> <p>This federal tag relates to complaint number IN00109199.</p> <p>3.1-5(a)(3)</p>				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, observation and interview the facility failed to develop a comprehensive plan of care (preventive measures i.e. float heels and pressure reduction mattress) to ensure a resident without pressure sores and at high risk for skin breakdown did not develop pressure sores for 1 of 3 residents with pressure sores. (Resident #89) .</p> <p>Findings include:</p> <p>On 6/12/12 at 11:12 a.m., Resident</p>	F0279	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident # 89: Care planned preventive measures including air flow mattress and the suspending of heels to prevent pressure while in the Broda chair. Initiated weekly review of resident condition during Risk Meeting; new interventions to be added as determined by the IDT until wounds are healed.</p> <p>How other residents having the</p>	07/19/2012	

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	<p>#89 was observed to be up in broda chair with a pillow under the resident's feet and heels were floated. On 6/1/312 at 10:15 a.m., the resident was observed to be up in a broda chair. The resident's feet were positioned on a foot rest without full pressure to heels.</p> <p>On 6/14/12 at 10:10 a.m., Resident #89 was observed to be up in broda chair with feet on a foot rest. The heels were not positioned with pressure. On 6/14/12 at 1:45 p.m., the resident was observed to be lying in bed with heels floated utilizing a floatation device.</p> <p>During interview of the Assistant Director of Nursing (ADON) on 6/12/12 at 10:34 a.m. the ADON indicated the resident had a healing current stage II originally unstageable pressure area to her Right heel and a healing unstageable pressure area to the left heel. The ADON indicated the pressure areas were acquired in the facility after the resident returned with a fractured hip.</p> <p>During review of the clinical record of Resident #89 on 6/14/12 at 3:30 p.m., the record indicated the resident fell and fractured left hip in the facility on 2/17/12. The resident returned to the</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <ul style="list-style-type: none"> <li>· Residents at high risk for skin breakdown have the potential to be affected by this deficient practice.</li> <li>· Nurses will be re-educated on current skin management policies related to the development of a comprehensive plan of care utilizing Preventative Strategies to ensure a resident without pressure sores and at high risk for skin breakdown does not develop pressure sores.</li> <li>· A baseline audit of all current residents will be completed to identify residents with a Norton Score of 10 or less, and ongoing admission audits will be completed for residents admitted to the community. –Preventive interventions will be implemented, by updating all care plans. In addition written communication will be provided to the direct care staff. Residents at-risk will also be reviewed at the weekly Risk Meeting and care planned appropriately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</li> <li>· Initiation of the LCS Skin Management Program to ensure: The identification at the time of admission, re-admission or following a change in condition those residents at high risk for</li> </ul>		

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	<p>facility on 2/7/12, following open reduction and internal fixation of left hip. The admission note indicated the resident returned with staples to left hip and bruising to the entire right arm due to IV infiltration. No indication of skin concerns to heels were noted. A physician order was noted dated 3/2/12, of abductor splint between legs when in bed to avoid scissoring or crossing of legs.</p> <p>An initial plan of care was noted, dated 2/27/12, with a problem which included but was not limited to, Pressure Ulcer/Skin at risk. The only approach indicated was treatment of ice to left hip. A skin risk assessment was completed on 2/27/12 and indicated the resident with a Norton scale score of "5." This score indicated the resident to be at high risk and to initiate pressure prevention care. The resident's initial skin assessment dated 12/6/11, did not indicate the resident at high risk with a score of "14."</p> <p>During interview of the ADON and DON (Director of Nursing) on 6/18/12 at 4 p.m., the ADON indicated a care plan should have been established upon return to facility 2/27/12, to indicate the resident's high risk of pressure sores and establish</p>		<p>skin breakdown.</p> <ul style="list-style-type: none"> <li>· Initiation of the LCS Skin Management Program to ensure: The development of care plans and implementation of preventive measures following the identification of a resident at high risk for skin breakdown.</li> <li>· Nurses will be re-educated on wound care procedures with emphasis on preventative measures.</li> <li>· Residents with a Norton assessment score of 10 or less will be reviewed weekly at the Risk Team meeting and ensure that a care plan is in place and that the plan is comprehensive in nature and ensures that each resident who is assessed at high risk for skin breakdown has preventative measures in place.</li> <li>· All new admissions and re-admissions will be reviewed by the Inter Disciplinary Team (IDT) at the weekly care plan meeting and as needed at following meetings.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> <li>· The Wound Nurse or designee will audit for residents with Norton Assessment scores that put them at high risk for skin breakdown.</li> <li>· The Risk Team and the Inter Disciplinary Team will audit compliance with the requirement to develop a comprehensive plan of</li> </ul>				

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	<p>approaches for prevention of pressure sores.</p> <p>3.1-35(b)(1)</p>		<p>care to ensure any resident without pressure sores and at high risk for skin breakdown does not develop Pressure sores.</p> <ul style="list-style-type: none"> <li>· Audit results of Norton scores and care planning of preventative measures for residents with a score of 10 or less will be communicated to the full QA Committee @ the next scheduled meeting which is July, 17 and then quarterly for one year.</li> <li>· Continuation of reporting beyond will be dependent on audit results and resolution of deficient practice.</li> </ul> <p>Completion Date: July 19, 2012</p>		

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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure that a resident without pressure sores did not develop pressure for 1 of 3 residents that met the criteria for pressure sores. The facility failed to implement preventive measures i.e. ensuring floating of heels and implementation of pressure reducing mattress of a resident at risk of skin breakdown after hip fracture. This resulted in resident developing unstageable pressure sores on bilateral heels. (Resident #89) .</p> <p>Findings include:</p> <p>On 6/12/12 at 11:12 a.m., Resident #89 was observed to be up in broda chair with pillow under feet and heels were floated. On 6/1/312 at 10:15 a.m., the resident was observed to be up in a broda chair. The resident's feet were positioned on foot rest</p>	F0314	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident # 89: : Care planned preventive measures including air flow mattress and the suspending of heels to prevent pressure while in the Broda chair. Initiated weekly review of resident condition during Risk Meeting; new interventions to be added as determined by the IDT until wounds are healed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <ul style="list-style-type: none"> <li>· Residents at high risk for skin breakdown have the potential to be affected by this deficient practice.</li> <li>· Reviewed the Norton assessments and scores for each resident to ensure that resident's scoring at high risk for skin breakdown have preventative</li> </ul>	07/19/2012			

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	<p>without full pressure to heels.</p> <p>On 6/14/12 at 10:10 a.m., Resident #89 was observed to be up in broda chair with feet on foot rest. The heels were not positioned with pressure. On 6/14/12 at 1:45 p.m., the resident was observed to be lying in bed with heels floated utilizing a floatation device.</p> <p>During interview of the Assistant Director of Nursing (ADON) on 6/12/12 at 10:34 a.m. the ADON indicated the resident had a healing current stage II originally unstageable pressure are to her right heel and a healing unstageable pressure area to the left heel. The ADON indicated the pressure areas were acquired in the facility after the resident returned with a fractured hip.</p> <p>During review of the clinical record of Resident #89 on 6/14/12 at 3:30 p.m., the record indicated the resident fell and fractured [resident's] left hip in the facility on 2/17/12. The resident returned to the facility on 2/7/12, following open reduction and internal fixation of left hip. The admission note indicated the resident returned with staples to left hip and bruising to entire right arm due to IV infiltration. No indication of skin concerns to heels were noted. A physician order</p>		<p>measures in place and those residents have a care with preventative measures in place.</p> <ul style="list-style-type: none"> <li>· Completed a facility-wide inventory of all mattresses recording type of mattress used by each resident to ensure that a mattress with pressure reduction properties is in place for any resident assessed as at risk for skin breakdown.</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>· Ensure all residents will be assessed at admission and those at high risk for skin breakdown will immediately be placed on a mattress with pressure reduction properties. Charge nurse to notify Wound care nurse and central supply clerk at admission for need of mattress with preventative properties with all Norton Assessment scores of 10 or less.</li> <li>· Central Supply Clerk or designee will maintain an inventory of all mattresses recording the type of mattress each resident is using to be reviewed at the weekly Risk meeting</li> <li>· Residents with a Norton assessment score of 10 or less will be reviewed weekly at the Risk Team meeting.</li> <li>· Nurses will be re-educated on current policies related to the development of a comprehensive plan of care to ensure a resident</li> </ul>		

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	<p>was noted dated 3/2/12 of abductor splint between legs when in bed to avoid scissoring or crossing of legs.</p> <p>An initial plan of care was noted, dated 2/27/12, with a problem which included but was not limited to, "Pressure Ulcer/Skin at risk". The only approach indicated was treatment of ice to left hip. A skin risk assessment was completed on 2/27/12, and indicated the resident with a Norton scale score of "5." This score indicated the resident to be at high risk and to initiate pressure prevention care. The resident's initial skin assessment dated 12/6/11, did not indicate the resident at high risk with a score of "14."</p> <p>A physician order was noted dated 3/12/12, of apply granulex spray to bilateral heels bid for 14 days then reassess. A nursing note dated 3/14/12, at 6:30 a.m. indicated the following: " Weekly wound rounds done, area 12 staples top area scant clear to pink dried drainage. [below] area 3 staples. Staples to be removed today area healed x 1." Another nursing note dated 6/14/12 at 6:45 a.m., indicated bilateral heels black unstageable, Right heel 6 [cm] x 4 [cm] dark black firm [no] drainage. L [left] heel 4 [cm] x 3 [cm] dark black</p>		<p>without a pressure sore and at high risk for skin breakdown does not develop a pressure sore and appropriate interventions are in place and care planned.</p> <ul style="list-style-type: none"> <li>· Nurses will be re-educated on The Initial Nursing Assessment – Part 8 and the initiation of pressure prevention care. The Risk Team will ensure that a care plan is in place and that the plan is comprehensive in nature and ensures that each resident who is assessed at high risk for skin breakdown has appropriate preventative measures in place.</li> <li>· All new admissions, re-admissions and any resident with a change in condition will be reviewed by the Inter Disciplinary Team (IDT) at the weekly care plan meeting and as needed at following meetings.</li> <li>· Initiate the LCS Skin Standard Protocols to ensure the development of care plans and implementation of preventive measures to ensure that a resident without a pressure sore and at high risk for skin breakdown does not develop a pressure sore.</li> <li>· Wound sheets have been updated to include Bed type. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</li> <li>· The Wound Nurse or designee will audit for residents with Norton Assessment scores that put them at high risk for skin breakdown.</li> </ul>				

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	<p>firm [no] drainage. float heels in bed . no shoes. granulex bid [twice daily] x 14 days. cont [continue] weekly wound rounds." A physician order was noted dated 3/16/12, of granulex and Mepilex to heels every day x 14 days. A physician order was noted, dated 3/22/12, of "discontinue order for granulex and Mepilex" and ordered "cover bilateral heels with protective dressing after betadine scrubs." A physician order was noted, dated 3/23/12, of Santyl to right heel and left heel daily. A physician order was noted, dated 6/6/12, of "cleanse pressure area with normal saline and cover with dry dressing to right heel" and "continue santyl ointment to pressure sore on left heel daily."</p> <p>A current plan of care was noted, dated 3/14/12, addressing the unstageable pressure sores to left and right heels. The approaches included but were not limited to, provide treatment, monitor every shift for signs and symptoms of infection (foul odor, increased temperature, redness at site, purulent drainage, etc) and record findings in nurses notes. Report s/s [signs/symptoms] of infection to M.D. Measure and record size weekly, pressure reduction devices: float heels in bed and turn and reposition every two hours; and</p>		<ul style="list-style-type: none"> <li>· The Risk Team and the Inter Disciplinary Team will audit compliance with the requirement to develop a comprehensive plan of care to ensure any resident without pressure sores and at high risk for skin breakdown does not develop pressure sores.</li> <li>· Audit results of Norton scores and care planning of preventative measures for residents with a score of 10 or less will be communicated to the full QA Committee @ the next scheduled meeting which is July, 17 and then quarterly for one year.</li> <li>· Continuation of reporting beyond a year, will be dependent on audit results and resolution of deficient practice.</li> </ul> <p>Completion Date: July 19, 2012</p>				

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	<p>leave shoes off.</p> <p>The following measurements were noted for 6/6/12: Left heel 3 cm x 2.5 cm with 0.2 cm depth unstageable without tunneling or drainage with surrounding area intact, pink and white with dark black center. Right heel 0.4 cm x 1 cm without depth, no drainage, wound edges intact with peeling skin, surrounding skin intact pink and white.</p> <p>On 6/15/12 at 12:55 p.m. the resident's pressure sore treatment was observed. The ADON completed the treatment. The right heel was observed to be pink with dry skin noted, and measured 0.3 cm x 0.7 cm. The area was cleansed with normal saline and cover with dry gauze and kerlix. The left heel was observed to have a soft , movable black center. The area measured 3.3 cm x 2.7 cm. The area was cleansed with normal saline and santyl ointment was applied. The area was covered with gauze and kerlix.</p> <p>During interview of CNAs #5 and #11 on 6/15/12 at 9:30 a.m., the CNAs indicated hospice had ordered the broda chair for the resident to allow less pressure on the resident's heels when up. The CNAs indicated the</p>						

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	<p>resident's heels were floated with a floatation device when in bed.</p> <p>Interview of the ADON on 6/15/12 at 12:10 p.m., the ADON indicated the resident had never been on air alternating bed, and was high risk upon return from the hospital due to a fracture hip. The ADON indicated the facility had attempted to use pillows to float heels and bilateral heel cushions. The ADON indicated she could not verify the use from 2/27/12 to 3/12/12. The ADON indicated a plan of care to float heels was not noted as established until 3/12/12 (onset date of bilateral unstageable heel pressure sores.) The ADON indicated a care plan to float heels was established after breakdown on 3/12/12.</p> <p>During Interview of the Director of Nursing(DON), on 6/18/12 at 10:30 a.m., the DON indicated the resident has always been on a Geo -Mattress Series: which has some pressure reduction properties.</p> <p>On 6/18/12 at 12 p.m., with ADON present , the resident's mattress was observed. The mattress was noted not to be a GEO series mattress. The mattress was noted to be blue in color, without a manufacturer's name.</p>						

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	<p>During interview of ADON and DON on 6/18/12 at 4 p.m., both indicated that a new mattress had been ordered for the resident on 6/18/12 and that they thought the resident had been on a GEO series mattress. The ADON indicated a care plan should have been established upon return to facility 2/27/12 to indicate the resident's high risk of pressure sores and to establish approaches for prevention of pressure sores. The ADON also indicated the resident's current mattress did not have pressure reduction properties. The ADON indicated the resident had been on this mattress since return on 2/27/12.</p> <p>3.1-40(a)(1)</p>			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to 1. maintain indwelling urinary catheters in a manner to prevent infections for 2 of 3 random observations of residents utilizing urinary catheters. [Residents #26 and #104] 2. Obtain a physician ordered urinalysis on a timely basis for 1 of 19 residents reviewed in stage 2. (Resident B)</p> <p>Findings include:</p> <p>1. During initial tour on 6/11/12 at 11:20 a.m. LPN #14 indicated Resident #26 utilized an indwelling Foley catheter.</p> <p>On 6/12/12 at 3:00 p.m. Resident #26 was observed in a low bed with an indwelling foley catheter. The drainage bag and tubing were</p>	F0315	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p><b>Resident # 26</b> This resident is no longer in our facility- d/c date 6/14/2012</p> <p><b>Resident # 104</b> This resident is no longer at our facility-d/c date 6/14/2012</p> <p><b>Resident B</b> is now clear from VRE and no longer on isolation</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b></p> <p>· Residents with indwelling urinary catheters have potential to be affected by this deficient practice.</p>	07/19/2012

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	<p>observed to be in contact with a blue floor mat next to the resident's bed.</p> <p>Resident #26's clinical record was reviewed on 6/14/12 at 2:00 p.m. A physician's order was noted dated April 2012 to transfer resident to hospital for insertion of supra-pubic catheter.</p> <p>The resident's diagnoses included, but was not limited to history of urinary tract infection, urinary retention.</p> <p>A plan of care dated 6/4/12 was noted of :Foley cath to promote wound healing stage 4 decub and urinary retention. Approaches included: monitor color and consistency of output, monitor I and O s [intake and outputs], monitor patency q [every] shift, Foley catheter care every shift and prn [as needed]. Change f/c per facility policy and if leaking, not draining or dislodged.</p> <p>2. During initial tour on 6/11/12 at 11:20 a.m., LPN #14 was interviewed. The LPN indicated Resident #104 utilized an indwelling Foley catheter.</p> <p>On 6/12/12 at 3:00 p.m. Resident #104 was observed in bed and to</p>		<ul style="list-style-type: none"> <li>· Review with all nursing staff including C N A's on the facility policy on Urinary Catheter Care.</li> <li>· Nurses will be re-educated on current policies related to maintaining indwelling urinary catheters in a manner to prevent infections and the process for obtaining a physician-ordered urinalysis.</li> <li>· Daily C N A Report Sheet will include a reminder to maintain tubing and catheter bag free from contact with the floor at all times. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></li> <li>· Compliance issues of all residents with indwelling urinary catheters and rounds of those with urinary catheters will be reviewed, when discussing infection control at the weekly Risk meeting.</li> <li>· All new physician orders including lab orders for urinalyses and cultures will be reviewed by the Quality Assurance Clinical Inter Discipline Team (QA-IDT) following the stand-up meeting.</li> <li>· The status of new orders for Urinalysis/Culture and Sensitivity will be followed by the (QA-IDT) and the Charge Nurse ultimately responsible for each shift until timely results are obtained and any necessary response is received from the doctor.</li> <li>· Initiate the LCS Bowel and</li> </ul>				

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	<p>have an indwelling Foley urinary catheter. The drainage tubing was observed to be in contact with floor.</p> <p>Resident #104's clinical record was reviewed on 6/19/12 at 3:00 p.m. A Minimum Data Set [MDS] assessment, dated 4/11/12 included the diagnosis of metastatic cancer. The assessment coded the resident as utilizing a Foley catheter.</p> <p>Admission diagnoses included, but was not limited to unknown primary liver metastasis and urinary retention.</p> <p>A physician's progress note dated 4/21/12 was noted to treat urinary tract infection and possible sepsis.</p> <p>A physician's progress note dated 5/14/12 was noted of "Place f/c [Foley catheter 5/21 for chemo. [chemotherapy].</p> <p>Readmission diagnoses dated 6/7/12, included, but were not limited to: urinary tract infection, sepsis, anemia, dehydration, elevated liver enzymes, abdominal malignancy, stage II sacral wound, DVT, [deep vein thrombosis] LUE, [left upper extremity], hypokalemia and constipation.</p> <p>A facility policy titled "Catheter Care,</p>		<p>Bladder Standard Protocols to ensure indwelling urinary catheters are maintained and infection control procedures are followed with special emphasis on maintaining both tubing and bag free from contact with the floor especially when the bed is in the low position.</p> <ul style="list-style-type: none"> <li>Initiate the LCS Bowel and Bladder Protocols to ensure that the appropriate treatment and infection control protocols for preventing urinary tract infections are followed.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b></p> <ul style="list-style-type: none"> <li>DON will develop an Audit tool and daily rounds will be done on all residents with urinary catheters for two weeks and then weekly. Audit of the number unresolved physician contacts and status of new orders for Urinalysis/Culture and Sensitivity will be followed by the (QA-IDT) and the committee at the next scheduled meeting which is July 17, 2012 and then quarterly for a year.</li> <li>Continuation of reporting beyond a year will be dependent on audit results and resolution of the deficient practice.</li> </ul> <p><b>Completion Date: July 19, 2012</b></p>		

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	<p>Urinary" revised October 2010, provided by DON on 6/19/12 at 9:06 a.m. included, but was not limited to "Cath care: Infection Control 2. b. Be sure catheter tubing and drainage bag are kept off the floor."</p> <p>2. Resident B's clinical record was reviewed on 06/19/12 at 12:12 p.m.</p> <p>Documentation indicated Resident #B had been admitted with diagnoses which included, but were not limited to, IDDM (insulin dependent diabetes mellitus), history of UTI's (urinary tract infections), COPD (chronic obstructive pulmonary disease), stroke, HTN (hypertension), GERD (gastroesophageal reflux disease), coronary artery disease, and history of pneumonia.</p> <p>The most recent Quarterly Nursing Assessment dated 04/04/12, indicated the resident was totally incontinent due to a history of CVA (cerebral vascular accident), was aphasic, and was a Hospice patient.</p> <p>A Quarterly assessment dated 02/29/12, indicated the Resident was totally dependent for all ADL's</p>			

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	<p>(activities of daily living) and incontinent of both bowel/bladder with no potential for training.</p> <p>A Significant change assessment dated 04/04/12 indicated the same regarding ADL's and incontinence.</p> <p>A plan of care identifying a problem dated 02/27/12, of Urinary/bowel incontinence due to history of CVA, indicated the resident was unaware of urinary/bowel incontinence.</p> <p>Nurse's notes dated 6/3/12 at 1:15 p.m., indicated the resident had vomited a moderate amount of undigested food. The resident's temperature was documented as 98.4.</p> <p>On 06/03/12 at 1:15 p.m., nurses notes indicated the resident vomited a moderate amount undigested food and Temperature was 98.4.</p> <p>On 06/04/12 at 2:45 p.m. nurses note indicated "Contacted Hospice to clarify order received 06/01/12. Order just noted."</p> <p>On 06/04/12 at 2:30 p.m. a nurses note indicated "U/A (urinalysis) [specimen] obtained c (with) st. (straight) cath..."</p>						

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	<p>Documentation from 6/05/12 to 6/09/12 was lacking regarding the U/A - C &amp; S (culture and sensitivity) results.</p> <p>On 06/10/12 at 10:45 a.m., nurses notes indicated Hospice was notified that Resident #B's urine specimen collected on 06/04/12, was identified to have VRE (Vancomycin Resistant Enterococcus). The Hospice nurse which had been contacted by the facility nurse had then directed the facility nurse to "Fax (facsimile) the C &amp; S results &amp; (and) initiate isolation protocol per facility policy". This entry also indicated the Hospice "would follow up with Dr.---tomorrow (06/11/12) for new orders".</p> <p>On 6/10/12 at 10:45 a.m. a nurses note indicated "Isolation initiated. C &amp; S faxed yesterday evening".</p> <p>On 6/11/12 10:30 a.m. a nurses note indicated "Dr. ---'s office called to verify allergy NKA (no known allergies..."</p> <p>On 6/12/12 at 9:30 a.m. nurses notes indicated "No return call from Dr.-- -Hospice called..."</p> <p>Nurses notes on 6/12/12 at 10:40</p>			

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	<p>a.m. indicated "Dr.--- 's office returned call. N.O. (new order) received for Ampicillin 500 mg (milligrams) bid (2 times daily) x (times) 10 days VRE. Hospice nurse informed..."</p> <p>Nurses notes on 6/12/12 @ 10:50 a.m. indicated the antibiotic was initiated from the EDK (emergency drug kit).</p> <p>A telephone order dated 06/01/12, indicated "Received at Hospice office 5/29/12: Do ..., U/A and C&amp; S"</p> <p>A telephone order dated 6/04/12 indicated "Clarification order of 06/01/12: Do ..., U/A-C &amp; S. May st cath..."</p> <p>Review of the lab section of the resident's clinical record failed to contain the C &amp; S lab report which indicated the resident had VRE in her urine from sample collected on 06/04/12.</p> <p>During interview on 06/13/12 at 11 a.m., with the ADON the ADON presented a urine C &amp; S lab report at 11:12 a.m., which indicated the resident had VRE (report was</p>						

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	<p>indicated as finalized 06/09/12). The ADON indicated the lab automatically faxes lab reports once the reports are finalized. The ADON was unable to provide a C &amp; S of urine lab report with documentation supporting the date which had been faxed to the facility.</p> <p>During Interview 06/15/12 at 12:30 p.m., the ADON stated she was not aware of any problems with the resident's UTI not having been treated in timely manner until 06/10/12, as a floor nurse had found the problem at that time. The ADON stated she was aware the resident's physician had to be called two times for ATB (antibiotic) order for treatment of the resident's VRE which had not been received until 06/12/12.</p> <p>A policy entitled "Palliative/End of Life Care--Clinical Protocol" with a revised date of October 2010 indicated "Treatment/Management: ...3. The physician will order a hospice evaluation as indicated...If hospice becomes involved in the care of the resident:...f. The hospice and facility will communicate with each other when any other changes are indicated or made to the plan of care..."</p>						

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	3.1-41(a)(2)				

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F0371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and record review the facility failed to serve food under sanitary conditions for 2 of 3 meal service observations in 1 of 3 kitchen areas in that soiled gloves were observed utilized in contact with interior services of clean dishes and in contact with food items, and plate covers utilized to serve room trays were observed with wet interiors. This had the potential to affect 35 of 70 residents.</p> <p>Findings include:</p> <p>1. On 6/11/12 at 11:42 a.m. the second floor satellite kitchen was observed during noon meal service. Dietary staff #12 was observed wearing gloves and preparing trays at the steam table. Dietary staff #12 was observed to leave the steam table multiple times while wearing gloves, opened cabinet doors, drawers, the microwave, exit door, bread sacks, opened a can of soup and return to steam table without changing gloves.</p>	F0371	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>· No resident suffered an adverse effect as a result of the deficient practice.</li> </ul> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <ul style="list-style-type: none"> <li>· All residents receiving meal service have the potential to be affected by the deficient practice(s).</li> <li>· All plate covers were examined and plate covers with wet interiors were immediately replaced with dry plate covers.</li> <li>· Cook assistance was provided that ensured safe handling of food with specific instructions re hand hygiene.</li> <li>· Dish machine was inspected and adjustments made to enhance the plate drying process on (7/3/12)</li> <li>· Removed existing drying rack and replaced it with alternate method to insure appropriate</li> </ul>	07/19/2012			

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	<p>With the contaminated gloves on the staff member was observed to touch the interior surfaces of the serving dishes, and handled buns and french fries.</p> <p>During the meal service 21 plate covers, stacked on top of each other, stored as clean, were observed with dripping wet interiors. The covers were observed to be utilized for service of room trays.</p> <p>2. On 6/18/12 at noon with the Dietary Manager present the second floor noon meal service was observed. Dietary staff #14 was observed to be preparing the trays at the steam table. The staff member was observed to be wearing gloves. The staff member was observed to leave the service area multiple times while wearing the gloves opened the microwave, refrigerator, handled paper menus for each resident, picked up cans of pop stored on top of the refrigerator, opened a cart brought from the main kitchen to obtain dessert items. The staff member was observed while wearing the same gloves to be intact with the interior services of the serving dishes and potato wedges.</p> <p>Five of 5 clear plastic plate covers</p>		<p>drying of all plate covers on (6/21/2012)</p> <ul style="list-style-type: none"> <li>· All dietary staff will be re-educated on appropriate preparation, distribution and serving of food under sanitary conditions ensuring that soiled gloves do not come in contact with the interior of clean dishes or in contact with food items.</li> <li>· All dishwashing staff will be re-educated on maintaining sanitary conditions by ensuring that plate covers utilized to serve room trays are dry.</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>· Dish machine was inspected and adjustments made to enhance the plate drying process on (7/3/12) Machines are inspected on a regular basis. Eco Lab dry rinse agent with tracking system which will be review bi-weekly by the kitchen manager. The Food and Beverage Supervisor or designee will check interior of plate covers for wetness prior to stacking.</li> <li>· The Food and Beverage Supervisor or designee will observe the dietary staff preparing trays and plating meals in dining room and document findings for at least one meal per day for a two week period, and then observe on a weekly basis for one month period to verify compliance with safe food</li> </ul>		

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	<p>were observed to be utilized to serve room trays. The covers were observed with visibly wet interiors. The Dietary Manager was interviewed at that time. The Manager indicated the week before it had been addressed that the plate covers were not always being dried on the drying racks and staff had been inserviced.</p> <p>A facility policy titled "Employees-Personal Cleanliness" dated 2011, provided by the DON on 6/19/12 at 9:06 a.m. included but was not limited to, Gloves should be used when handling food. Gloves should be thrown away after use. Food should not be touched directly with hands. All plates and trays should be handled so fingers do not touch eating surfaces."</p> <p>A dietary policy [no date] provided by the Registered Dietician [RD] on 6/19/12 at 11:00 a.m. under the section titled "How to Operate the Dishmachine," included, but was not limited to, "5. Remove the items as they emerge from exit of machine. Allow all items to air dry before putting them away. ..."</p> <p><b>3.1-21(i)(3)</b></p>		<p>handling techniques.</p> <ul style="list-style-type: none"> <li>Implemented drying racks to insure appropriate drying of all plate covers (6/21/2012)</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> <li>Audit results which will identify number of unsafe food handling techniques observed and a progress report of safe food handling and staff re-education will be communicated to the full QA Committee and then quarterly for a year.</li> <li>Continuation of reporting will be dependent on audit results and resolution of the problem.</li> </ul> <p>Completion Date: July 19, 2012</p>				

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F0387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility failed to assure that a resident received timely physician visits for the overseeing of care for 1 of 2 resident's reviewed for physician visits in a sample of 19 (Resident #B).</p> <p>Findings include:</p> <p>During record review 06/19/12 at 12:12 p.m., documentation indicated Resident #B had been admitted on 01/28/11, with the diagnoses which included, but were not limited to, IDDM (insulin dependent diabetes mellitus), history of UTI's (urinary tract infections), COPD (chronic obstructive pulmonary disease), stroke, HTN (hypertension), GERD (gastroesophageal reflux disease), coronary artery disease, and history of pneumonia.</p> <p>The most recent Physician's progress note indicated a date of 12/13/11.</p>	F0387	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident # B</p> <ul style="list-style-type: none"> <li>· An appointment was made for resident to see primary care physician on 7/11/12.</li> <li>· Medical director was notified.</li> </ul> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <ul style="list-style-type: none"> <li>· All residents with the same physician as Resident B have the potential to be affected by this deficient practice.</li> <li>· Scheduler educated the resident's family regarding the requirement for timely physician visits in order to oversee care.</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the</p>	07/19/2012			

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	<p>During interview on 06/1512 at 12:30 p.m., the ADON (Assistant Director of Nursing) stated the facility was aware of an existing problem with the resident's physician not making timely rounds at the facility. The ADON indicated, "The resident is related to this physician and the family won't change doctors. The ADON verified at this time the resident had not been seen by a physician since 12/13/11. The ADON further indicated the Medical Director (who is not the resident's physician) refuses to make rounds for those physicians who refuse to make rounds for their own respective patients.</p> <p>3.1-22(d)(1)</p>		<p>deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>· Scheduler or designee will maintain contact with resident's family members, advise them when physician visits and due, assist with appointments to ensure compliance.</li> <li>· Noncompliance by either family or physician is to be reported to DON for follow up.</li> <li>· Medical Records Clerk or designee will maintain medical records audits and will document the frequency and timeliness of physician visits on a monthly basis.</li> <li>· Audit results and a progress report will be communicated to the full QA Committee and then quarterly as needed.</li> <li>· Continuation of reporting will be dependent on audit results.</li> <li>· Medical Records and will immediately notify scheduler of any untimely visits.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Medical Records Clerk or designee will audit physician compliance with the physician visit frequency and timeliness requirement.</p> <ul style="list-style-type: none"> <li>· Audit results will be communicated to the full QA Committee each month</li> </ul> <p><b>Completion Date: July 19th,</b></p>	

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observations, record review</p>	F0441	What corrective action(s) will be accomplished for those	07/19/2012	

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	<p>and interview, the facility failed to ensure staff providing incontinence care, wore gowns to prevent soiling of their uniforms when and failed to ensure staff changed gloves after incontinence care, to prevent soiling of the environment. This included a sample of 4 of 6 CNAs (CNA #'s 1, 2, 3, and 5)observed providing incontinence care, and 3 of 3 residents observed receiving incontinence care.(Resident #'s 18, 28 and Resident B)This had the potential to affect 35 (residents residing on 1st floor) of 70 residents.</p> <p>Findings include:</p> <p>1. During initial tour 06/11/12 which began at 11:50 a.m., an odor was observed in resident #28's room.</p> <p>During interview of RN #7, on 6/11/12 at 12 noon, the RN indicated the resident was having loose stools and an order had been received for a stool culture to identify if the resident has Clostridium Difficile (c-diff). The nurse indicated the resident had been</p>		<p><b>residents found to have been affected by the deficient practice: Resident # 18 - resident is still in our facility recent test results are now negative however continues to have loose stools . Resident # 28 - appropriate peri-care maintained no acquired infections at this time. Resident # B - resident is in our facility and now VRE free and off precautions. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· Residents incontinent of bowel and bladder have potential to be affected by this deficient practice.</li> <li>· Nursing staff will be re-educated on current policies related to infection control with emphasis on hand washing, universal precautions, gowning and gloving to prevent soiling uniforms while providing incontinence care.<b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></li> <li>· Initiate the LCS Bowel and Bladder Protocols to with emphasis on infection control protocols, providing incontinence care, wearing gown to prevent soiling of uniforms and changing glove after care.</li> <li>· C N A's # 1, 2, 3, &amp; 5 have been counseled regarding proper peri-care which</li> </ul>		

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	<p>diagnosed with c-diff in April 2012 and was treated.</p> <p>On 6/12/12 at 10:15 a.m. CNA #'s 1, 2, and 3 were caring for Resident #28. The Resident was observed with a large loose stool. The CNAs were not wearing gowns over their uniforms. All three CNAs leaned up against the bed. CNA #2 stretched across the resident to assist with placing clean linens on the resident's bed.</p> <p>During Interview of CNA #'s 2 and 3 on 6/12/12 at 11:15 a.m., the CNAs indicated the resident was not in precautions.</p> <p>During interview of the ADON on 6/12/12 at 2 p.m., the ADON indicated the resident was having loose stools and had a recent history of Clostridium Difficile. The ADON indicated they were waiting for the results to know whether they need to place the resident in isolation.</p>		<p>includes when to wash hands and change gloves. The nursing staff will be re-educated by the SDC on policy and procedure regarding incontinent care which includes standard precautions of washing hands and changing gloves. The DON, SDC or ADON will perform peri care observations daily of C N A staff at least 5 days a week until all shifts have been observed and satisfactorily performed the peri care procedure. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Once that is achieved then continued observing peri care at least weekly for another month to assure continued appropriate practice. The DON, SDC and ADON will bring results of auditing observations to the QA meeting and then quarterly thereafter as needed; however the monitoring rounds will continue to be done on an ongoing basis. <b>Completion Date: July 19, 2012</b></p>	

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NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
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	<p>On 6/14/12 10:48 a.m., Resident #28's clinical record was reviewed</p> <p>A Physician's order, dated 6/11/12 at 2 p.m. , indicated "Obtain stool sample for c-diff", along with an order for "Vancomycin 250 mg qid x 10 days loose stools, start after sample obtained."</p> <p>A nurses note, date 6/9/12, at 2:00 a.m. indicated "T-99.1.... total 3 loose stools this shift [plus] odor, monitoring"</p> <p>On 6/10/12 at 8:30 p.m. nurses notes indicated "loose stools reported x 1 per CNA foul odor noted, monitoring"</p> <p>A nurses note, dated 6/11/12, 2:25 p.m.,indicated "loose foul smelling BM (bowel movement)noted this morning. Res (resident) in bed not feeling well ate a few bites of lunch and bkf."</p> <p>On 6/13/12 at 2:30 p.m., "Lg (large) loose stool noted today. On 6/14/12 at 12:05 p.m., results of stool for c-diff received from the ...lab. Positive for</p>						

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	<p>c-diff."</p> <p>Nurses notes on 6/14/12 at 12:10 p.m. indicated the management was notified of the culture results and the resident was being moved to a different room."</p> <p>Review of a facility policy titled "Standard Precautions" dated 12/2001, and received on 6/18/12 at 11:20 a.m., from the ADON, documentation indicated "Standard Precautions will be used in the care of all residents.... Standard Precautions presume that all blood, body fluids, secretions and excretions (except sweat) , non-intact skin and mucous membranes may contain transmissible infectious agents."</p> <p>Documentation under the title "Standard precautions include the following practices", indicated "wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing."</p>						

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	<p>2. On 6/14/12 at 10:25 a.m., Resident #18 was observed to be toileted by CNA # 5. The resident was observed to void while being toileted. With gloves on, CNA #5 was observed to provide pericare to the resident. Without changing her contaminated gloves, the CNA was observed to pull the resident's brief and slacks up before removing her gloves and washing her hands.</p> <p>3. Record review of Resident B on 06/14/12 at 10:30 a.m., indicated:</p> <p>A nurse's note dated 06/10/12 @ 10:45 a.m. Hospice was notified that resident's urine specimen collected 06/04/12, was identified to have VRE (Vancomycin Resistant Enterococcus). The Hospice nurse contacted by the facility nurse had then directed the facility nurse to fax the C &amp; S (Culture and Sensitivity) results and to initiate isolation protocol per facility policy.</p>			

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	<p>The most recent Quarterly Nursing Assessment dated 04/04/12, indicated the resident was totally incontinent due to history of CVA (cerebral vascular accident), was aphasic, and was a Hospice patient.</p> <p>A Quarterly assessment dated 02/29/12, indicated the Resident was totally dependent for all ADL's (activities of daily living) and incontinent of both bowel/bladder with no potential for training.</p> <p>A Significant change assessment dated 04/04/12 indicated the same regarding ADL's and incontinence.</p> <p>A plan of care identifying a problem dated 02/27/12, of Urinary/bowel incontinence due to history of CVA, indicated the resident was unaware of urinary/bowel incontinence.</p> <p>A problem identifying a UTI (urinary tract infection) with VRE (Vancomycin Resistant Enterococcus) was dated on 06/12/12, with intervention of Ampicillin 500 mg (milligrams) po (by mouth) bid (2 times daily) ... x (times) 10 days.</p> <p>On 06/12/12 @ 1:35 p.m., the</p>						

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	<p>following was observed: CNA #3 and CNA #4 transferred Resident #B from a wheelchair to the bed with a Hoyer lift. CNA #3 performed peri-care with gloved hands while CNA #4 assisted by rolling the resident to the side. CNA #3 used one disposable wipe to cleanse the resident's front area, then assisted CNA #4 to turn the resident to the left side. Without removing the contaminated gloves, CNA #3 had then assisted CNA #4 to turn the resident to her left side. CNA # 3 had then attained another disposable wipe from a multi-pack container and had performed incontinence care to the resident's rectal and buttock areas (Resident had been incontinent of urine and currently had the diagnosis of Vancomycin Resistant Enterococcus [VRE] in her urine). Both contaminated disposable wipes were put in the wet incontinence brief which had been folded up by CNA #3, with all contaminated articles then placed in an isolation container in the resident's room. CNA #3 had then taken the resident's call light cord and had handed it to CNA #4 for proper placement without removing the</p>			

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	<p>contaminated gloves and washing her hands. CNA #3 had then attained a single-use disinfectant wipe from the isolation supplies located in the resident's room, and had proceeded to wipe the Hoyer lift down 'since the resident had VRE' with the same gloves on that CNA #3 had started the peri-care process with.</p> <p>Review of a facility policy titled "Standard Precautions" dated 12/2001, and received on 6/18/12 at 11:20 a.m., from the ADON, documentation indicated "Standard Precautions will be used in the care of all residents.... Standard Precautions presume that all blood, body fluids, secretions and excretions (except sweat) , non-intact skin and mucous membranes may contain transmissible infectious agents." Documentation under the title "Standard precautions include "Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces....to avoid transfer of microorganisms to other residents or environments."</p>			

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