

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155524	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2015
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NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This survey was in conjunction with the Investigation of Complaint IN00179014.</p> <p>Survey dates: August, 4, 5, 6, 7, 10, 11, and 12, 2015.</p> <p>Facility number: 000230 Provider number: 155524 AIM number: 100275000</p> <p>Census bed type: SNF/NF: 124 Total: 124</p> <p>Census payor type: Medicare: 16 Medicaid: 84 Other: 24 Total: 124</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective 9-03-2015 to the state findings of the Recertification and State Licensure survey conducted on August 4, 5, 6, 7, 10, 11 and 12, 2015.	
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY			

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>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was dressed in their own clothing rather than a hospital gown for 1 resident observed for dignity (Resident #99), failed to ensure residents' private space was respected by knocking on the room door before entering the room for 2 of 2 randomly observed residents (Resident #179, Resident #181) and 1 of 1 resident observed during medication administration (Resident #99), and failed to ensure staff did not post resident information in the assisted dining room (Resident #5, Resident #10, Resident #15, Resident #25, Resident #26, Resident #51, Resident #52, Resident #60, Resident #61, Resident #64, Resident #71, and Resident #133).</p> <p>Findings include:</p> <p>Resident #99's clinical record was reviewed on 8/11/15 at 10:00 a.m. Diagnoses included, but were not limited to: stroke.</p> <p>The current quarterly Minimum Data Set (MDS) assessment indicated Resident #99 needed extensive assistance of 2 staff</p>	F 0241	<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 99 has been reassessed related to his preference on dressing attire and his care plan has been up-dated to reflect this level of assistance needed for dressing. Resident #99 is questioned by the nursing staff each day on his preference of clothing and the staff is assisting him in dressing each day in accordance with his preference. 2a). The corrective action taken for those residents found to be affected by the deficient practice is that the staff does not enter the room of the resident identified as resident #99 without first knocking before entering the room. 2b). The corrective action taken for those residents found to be affected by the deficient practice is that the nursing staff members do not enter the rooms of the residents identified as resident # 181 and #179 without first knocking before entering their rooms. 3). The corrective action taken for those residents found to be affected by the deficient practice is that the seating arrangement sign that was posted</p>	09/03/2015

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	<p>persons for dressing.</p> <p>1). On 8/5/15 at 11:08 a.m., Resident #99's wife indicated, Staff doesn't dress Resident #99, "They [indicating staff] keep him in a hospital gown."</p> <p>On 8/7/15 at 11:00 a.m., Resident #99 was observed to be in the bed asleep with a hospital gown on.</p> <p>On 8/10/15 at 10:45 a.m., Resident #99 was observed to be in bed asleep with a hospital gown on.</p> <p>On 8/11/15 at 9:42 a.m., Resident #99 was observed in bed asleep with a hospital gown on.</p> <p>The current care plan "ADL Assist Required" dated 6/9/15, indicated Resident #99 needed assist in, bed mobility, transfers, toileting, turn and reposition with assist of one. The care plan lacked documentation for assist with dressing.</p> <p>On 8/11/15 at 10:03 a.m., the 600 hall Unit Manager indicated Resident 99 gets unconformable when CNA's try to dress him. "When we get him up he starts yelling and goes back to bed." The 600 hall Unit Manager indicated there was no care plan for Resident #99 in regards to</p>		<p>on the wall in the assisted dining room has been removed. There is no resident information posted in public view for the residents identified as resident's # 5, # 10, # 15, # 25, # 26, # 51, # 52, # 60, # 61, #64, # 71, #133 and # 53. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. All residents are being dressed per their personal preference to promote the dignity of our residents. All staff is knocking on each resident's doors before entering their rooms and there are no signs posted with any resident information in any public area. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed its policy on residents' right and has included documentation regarding the posting of resident information in the facility. A mandatory in-service has been provided for all staff on the revised policy. The in-service included instruction on promoting the residents' dignity and honoring their personal preference related to dressing attire, knocking on residents' room doors before entering and the facility practice of not posting any resident information in public</p>				

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	<p>wearing a hospital gown at all times.</p> <p>On 8/11/15 at 10:14 a.m., interview with CNA #1 indicated, "We [indicating CNA's] try to dress Resident #99, but doesn't want pants on, because it hurts his b__t [buttock]."</p> <p>On 8/11/15 at 11:15 a.m., CNA #1 and CNA #2 were observed to provide activity of daily living care for Resident #99. CNA #2 removed the soiled hospital gown from Resident #99 and placed a clean hospital gown on Resident #99. CNA #1 nor CNA #2 were observed to ask Resident #99 if he wanted to put on personal clothing.</p> <p>On 8/11/15 at 3:00 p.m., the Administrator provided policy "...Activities of Daily Living" dated 6/1/204, and indicated the policy was the one currently used by the facility. The policy indicated, "...3. Dressing: Selecting, obtaining and putting on, fastening and taking off items of clothing ..."</p> <p>2a). On 8/6/15 9:05 a.m., LPN #3 was observed to enter Resident #99's room to administer medication and was observed not to knock before entering Resident #99's bathroom to handwash. LPN #3 walked over to Resident #99's bed to</p>		<p>areas. <i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool. The tool will monitor the residents' appearance to ensure the residents' dignity is promoted along with ensuring their privacy is respected through the staff's practice of knocking on the residents' doors before entering their rooms. The tool will also monitor to ensure that there are no postings of resident information in any public area throughout the facility. This tool will be completed by the Social Service Director and/or their designee. The tool will be completed every shift for seven days, then weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility regularly scheduled Quality Assurance Meetings to determine if any additional action is warranted.</i></p>	

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	<p>awaken the resident.</p> <p>b). On 8/11/15 at 8:35 a.m., RN #1 was observed to enter Resident #181's room without knocking and administer medications. RN #1 was observed to leave Resident #181's room, walked to the medication cart and retrieve Resident #179's medication. RN #1 was observed to enter Resident #179's room without knocking. RN #1 indicated she did not knock, because another staff member was already in both resident's room prior to RN #1 entering.</p> <p>On 8/11/15 at 1:35 p.m., the Administrator provided "Privacy policy" dated October 23, 2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...Assure residents have privacy during care. ...1. Staff members will knock on the door before entering. ..."</p> <p>3. On 8/4/15 at 12:43 p.m., during a dining observation, a seating arrangement sign was observed posted on the wall in the assisted dining room. The sign included a drawing of five tables, instructions which indicated for staff to put residents in the right area for all meals, and listed the 13 residents' names as follows:</p> <p>The residents assigned to table 1:</p>			

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	<p>Resident #51, Resident #52, and Resident #64.</p> <p>The residents assigned to table 2: Resident #5, Resident #10, and Resident #71.</p> <p>The residents assigned to table 3: Resident #15 and Resident #61.</p> <p>The residents assigned to table 4: Resident #26 and Resident #133.</p> <p>The residents assigned to table 5: Resident #25, Resident #53, and Resident #60.</p> <p>On 8/4/15 at 12:55 p.m., the Assistant Director of Nursing indicated she could see how there was a problem posting residents' names on a sign.</p> <p>On 8/4/15 at 1:09 p.m., the Director of Nursing indicated she did not know why the sign was posted, but it will never go back up again.</p> <p>On 8/11/15 at 1:35 p.m., the Administrator provided the policy, "Residents Rights," undated, and indicated it was the one currently being used by the facility. The policy lacked documentation regarding the posting of resident information in the facility.</p> <p>3.1-3(t)</p>			

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F 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure that residents were able to schedule what time to get up in the morning according to their preference for 1 of 5 residents who met the criteria for review of choices. (Resident #94)</p> <p>Findings include:</p> <p>Resident #94's clinical record was reviewed on 8/12/15 at 11:03 a.m. Diagnoses included, but were not limited to: depression, congestive heart failure, and atrial fibrillation.</p> <p>The current quarterly MDS (Minimum Data Set) assessment dated 6/26/15, indicated Resident #94 needed limited assistance of one staff person for bed mobility, transfers, walk in room, and personal hygiene. Resident #94 needed extensive assistance of one staff person</p>	F 0242	<p><i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 94 has been interviewed related to their personal choices on wake time. The resident #94 is now arising each morning according to their personal preference. Their care plan has been up-dated to reflect their personal preferences related to wake time and the CNA assignment sheet has been up-dated to reflect the resident's preference on waketime.</i></p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility's personal preference form has been reviewed and revised to include the resident choice on wake time. A house wide audit has been conducted utilizing the new personal preference form. Upon completion of the house wide audit, each resident's care plan was up-dated to reflect their personal preferences on wake time and the</i></p>	09/03/2015			

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	<p>for dressing.</p> <p>On 08/05/2015 at 10:13 a.m., Resident #94 indicated she was awoken by staff around 5:30 a.m., but would like to sleep until 7:00 a.m. Resident #94 indicated staff doesn't ask what time she would like to get up in the morning. "It's just standard, but we all have to get up early and go into the dining room for breakfast."</p> <p>The current care plan "Resident Preference for Customary Routine Care Plan" dated 7/14/15, lacked documentation for when Resident #94 preferred to awaken in the morning.</p> <p>Review of the current undated, CNA's (Certified Nursing Assistant) assignment sheet on 8/12/15, lacked documentation of Resident #94's preference on waking up in the morning.</p> <p>On 8/12/15 at 11:29 a.m., interview with the Activity Director indicated resident preference sheets are completed on admission, annually, and at a significant change. The form coincides with section F of the MDS (Minimum Data Set) assessment and staff/CNA's were responsible for the wake up time. "The nursing staff."</p>		<p>CNAassignment sheets have been up-dated with the current personal preferencechoices of each resident related to their decision on wake-up time.</p> <p><i>The measures orsystematic changes that have been put into place to ensure that the deficientpractice does not recur is that a mandatory in-service has been conductedfor all nursing staff, activity department staff and all social service staffon the revised facility personal preference tool. The staff was directed on the importance offollowing each resident's personal preferences including wake up time.</i></p> <p><i>The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by the development and implementation of aQuality Assurance tool. The tool willmonitor by interviewing residents to ensure that their personal preferences arebeing honored by the facility staff members including their preferences in wakeup time. This tool will be completed bythe Social Service Director and/or their designee weekly for four weeks, thenmonthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility regularly scheduled Quality Assurance Meetings to determine if anyadditional action is warranted.</i></p>				

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	<p>On 8/12/15 at 11:48 a.m., interview with the 600 hall's unit manager indicated there was a get up list. "Resident #94 has a group of ladies that she likes to eat with." The 600 hall unit manager indicated she usually asks the residents if they would like to eat in the dining room, if so she will put their names on the night shift get up list. The 600 hall unit manager indicated breakfast was from 7:00 a.m. to 8:00 a.m. or 9:00 a.m., and there was no reason Resident #94 could not sleep until later.</p> <p>On 8/12/15 at 11:40 a.m., CNA #4 indicated Resident #94 is always awake before the day shift comes on duty and she was in the dining room for breakfast.</p> <p>On 8/11/15 at 1:35 p.m., the Administrator provided policy "Resident Preferences/Choices dated 6/124/15, and indicated the policy was the one currently used by the facility. The policy indicated, "...Residents have the right to care based on personal preferences/choices. ...4. Residents' preferences/choices will be established in a care plan. ..."</p> <p>There was no documentation provided indicating Resident #94's wake up preference.</p> <p>3.1-3(u)(3)</p>				

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F 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;</p>			

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	<p>Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure the accuracy of the annual Minimum Data Set (MDS) assessment for 1 of 27 residents reviewed for MDS assessment accuracy. (Resident #2)</p> <p>Findings include:</p> <p>Resident #2's clinical record was reviewed on 8/7/15 at 11:32 a.m. Diagnoses include, but were not limited to: iron deficiency and anemia</p> <p>The current annual Minimum Data Set (MDS) assessment dated 12/3/14, oral/dental status indicated Resident #2 had no dental concerns.</p> <p>On 8/5/15 at 2:45 p.m., Resident #2 was observed in the TLC (Tender Loving Care) dayroom with the TLC Activity Aide present. The Activity Aide indicated</p>	F 0272	<p><i>The corrective action taken for those residents found to be affected by the deficient practice is that a corrected MDS assessment has been completed for the resident identified as resident # 2 which includes accurate dental/oral information on the resident.</i></p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide review of all MDS assessments has been completed to ensure that they contain accurate information related to the dental/oral information on each resident.</i></p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for each member of the facility that is responsible for the completion of any sections/parts of the MDS (Minimum Data Set). The in-service</i></p>	09/03/2015

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	<p>Resident #2 had no teeth. Resident #2 refused to open her mouth for observation of the inside of her mouth.</p> <p>On 8/10/15 at 2:17 p.m., interview with the Director of Nursing (DON) indicated, the selected box on the dental status portion of the MDS was incorrectly mark. The DON indicated, Resident #2 had no teeth.</p> <p>3.1-31(d)</p>		<p>included instructions on the importance of ensuring thatthe information completed on the MDS is accurate based on the currentassessments of each resident.</p> <p><i>The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by a Quality Assurance tool which has beendeveloped and implemented to monitor the accuracy of the content of the MDS(Minimum Data Set). This tool will becompleted by the Director of Nursing and/or her designee weekly for four weeks, thenmonthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility regularly scheduled Quality Assurance Meetings to determine if anyadditional action is warranted.</i></p>		

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F 0279 SS=D Bldg. 00	<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 interview and record review, the facility failed to ensure a resident's careplan was developed after assessment for a resident who did not want to wear clothing for 1 of 27 residents reviewed for care plans. (Resident #99)</p>	F 0279	<p><i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 99 has been reassessed related to his preference on dressing attire and his care plan has been up-dated to reflect his personal preference and the level of assistance needed for dressing.</i></p>	09/03/2015

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	<p>Findings include:</p> <p>Resident #99's clinical record was reviewed on 8/11/15 at 10:00 a.m. Diagnoses include, but were not limited to: stroke.</p> <p>The current quarterly Minimum Data Set (MDS) assessment indicated Resident #99 needed extensive assistance of 2 staff persons for dressing.</p> <p>On 8/5/15 at 11:08 a.m., Resident #99's wife indicated, the staff doesn't dress Resident #99 "They [indicating staff] keep him in a hospital gown."</p> <p>On 8/7/15 at 11:00 a.m., Resident #99 was observed to be in the bed asleep with a hospital gown on.</p> <p>On 8/10/15 at 10:45 a.m., Resident #99 was observed to be in bed asleep with a hospital gown on.</p> <p>On 8/11/15 at 9:42 a.m., Resident #99 was observed in bed asleep with hospital gown on.</p> <p>On 8/11/15 at 10:03 a.m., the 600 hall Unit Manager indicated Resident 99 gets unconformable when CNA's (Certified Nursing Assistance) try to dress him. "When we get him up he starts yelling</p>		<p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was completed on all residents related to their choice of dressing in street clothes for the day or to wear night clothes during the day. Any resident identified to prefer to remain in night clothes during the day has had their care plan up-dated to reflect this choice. The CNA assignment sheets have also been up-dated to reflect if a resident chooses to remain in night wear during the daytime.</i></p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all nursing staff including the MDS coordinators on ensuring that each resident's care plan addressed the resident's current needs and choices as it related to dressing attire. The staff was reminded on the importance of following each resident's plan of care as it relates to personal attire.</i></p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by a Quality Assurance tool which has been developed and implemented to monitor the resident's plan of care to ensure that it addresses the personal</i></p>	
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	<p>and goes back to bed." The 600 hall Unit Manager indicated there was no care plan for Resident #99 in regard to not wanting to wear clothing.</p> <p>On 8/11/15 at 10:14 a.m., interview with CNA #1 indicated, "We [indicating CNA's] try to dress Resident #99, but doesn't want pants on because it hurts his b__ t [buttock]."</p> <p>On 8/11/15 at 11:15 a.m., CNA #1 and CNA #2 were observed to provide activity of daily living care for Resident #99. CNA #2 removed the soiled hospital gown from Resident #99 and placed a clean hospital gown on Resident #99. CNA #1 nor CNA #2 were observed to ask Resident #99 if he wanted to put on personal clothing.</p> <p>On 8/11/15 at 3:00 p.m., the Administrator provided policy "...Activities of Daily Living" dated 6/1/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...3. Dressing: Selecting, obtaining and putting on, fastening and taking off items of clothing ..."</p> <p>There was no care plan provided indicating Resident #99 preferred to wear a hospital gown at all times.</p>		<p>preferences of each resident related to their choice in personal attire and the level of assistance needed to aid the resident in dressing daily. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility regularly scheduled Quality Assurance Meetings to determine if any additional action is warranted.</p>				

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	<p>facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician's orders were followed for residents with orders for antidiabetic medication to be given 1/2 hour before meals for 1 of 4 residents observed for medication administration. (Resident #54)</p> <p>Findings include:</p> <p>Resident #54's clinical record was reviewed on 8/11/15 at 8:50 a.m. Diagnoses include, but were not limited to: diabetes type 2.</p> <p>On 8/6/15 at 8:32 a.m., LPN #2 was observed during medication administration to dispense glipizide 5 mg (milligram) for Resident #54 after breakfast, when physician's order dated 8/1/15 to 8/31/15 indicated give 1/2 tablet before meals. LPN #2 indicated Resident #54 had already eaten breakfast. LPN #1 indicated she should get order clarification and not give the glipizide. "If we give at 6 a.m. [6:00 a.m.] that is still not 1/2 before meal." LPN #2 was observed to throw the glipizide in the trash.</p> <p>On 8/6/15 at 11:45 a.m., review of the</p>	F 0282	<p><i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 54 is now receiving their antidiabetic medication one-half hour before meals in accordance with the physician's orders. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide review of all current medication records has been completed to ensure that medications have been scheduled in accordance with physician's orders. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all licensed nurses and QMAs on the facility policy related to administering medications in accordance with the physician's orders. The in-service included special instructions on the following of administration times in accordance with physician's orders with a focus on antidiabetic medications. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and</i></p>	09/03/2015

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F 0309 SS=D Bldg. 00	<p>current physician's order dated 8/1/15 to 8/31/15, indicated "GLIPIZIDE 5 MG TABLET, TAKE 1/2 HOUR BEFORE MEALS, ..."</p> <p>Wolters Kluwer 35th Edition Nursing 2015 Drug Handbook, indicated, "... Glipizide ADMINISTRATION: P.O. [by mouth] Give immediate-release tablet about 30 minutes before meals. ..."</p> <p>On 8/12/15 at 11:11 a.m., the Director of Nursing provided policy "Medication Administration, Labeling, and Storage" dated 5/2014, and indicated the policy was the one currently used by the facility. The policy indicated, " ...1. Medications ordered to be administered by mouth, will be administered by license nurses ... in accordance with the physician's orders. ...19. ...[4] Right Time, ..."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>		<p>implementation of aQuality Assurance tool which will monitor the administration of medication inaccordance with the physician's orders. This tool will be completed by theDirector of Nursing and/or their designee daily for seven days, then weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility regularly scheduled Quality Assurance Meetings to determine if anyadditional action is warranted.</p>	

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	<p>Based on observation, interview, and record review, the facility failed to ensure residents were free from medication errors in that a antidiabetic medication was given after breakfast for 1 of 5 residents reviewed for unnecessary medication use. (Resident #54, LPN #2)</p> <p>Findings include:</p> <p>Resident #54's clinical record was reviewed on 8/11/15 at 8:50 a.m. Diagnoses include, but were not limited to: diabetes type 2.</p> <p>On 8/6/15 at 8:32 a.m. LPN #2 (Licensed Practical Nurse) was observed during medication administration to dispense glipizide 5 mg (milligram) for Resident #54 after breakfast, when physician's order dated 8/1/15 to 8/31/15 indicated give 1/2 tablet before meals. LPN #2 indicated Resident #54 had already eaten breakfast. LPN #1 indicated she should get order clarification and not give the glipizide. "If we give at 6 a.m. [6:00 a.m.] that is still not 1/2 before meal." LPN #2 was observed to throw the glipizide tablet in the trash.</p> <p>On 8/6/15 at 11:45 a.m., review of the current Physician's order dated 8/1/15 to 8/31/15, indicated "GLIPIZIDE 5 MG TABLET, TAKE 1/2 HOUR BEFORE</p>	F 0309	<p><i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 54 is now receiving their antidiabetic medication one-half hour before meals in accordance with the physician's orders. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide review of all medication records has been completed to ensure that medications have been scheduled in accordance with physician's orders. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all licensed nurses and QMAs on the facility policy related to administering medications in accordance with the physician's orders. The in-service included special instructions on the following of administration times in accordance with physician's orders with a focus on antidiabetic medications. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool which will monitor the administration of medication</i></p>	09/03/2015			

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F 0329 SS=E Bldg. 00	<p>MEALS, ..."</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, indicated, "... Glipizide ADMINISTRATION: P.O. [by mouth] Give immediate-release tablet about 30 minutes before meals. ..."</p> <p>3.1-37(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>		<p>inaccordance with the physician's orders. This tool will be completed by the Director of Nursing and/or their designee daily for seven days, then weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility regularly scheduled Quality Assurance Meetings to determine if any additional action is warranted.</p>				

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	<p>Based on interview and record review, the facility failed to ensure residents who received a psychotropic medication were monitored for targeted behaviors and for effectiveness of medications for 5 of 5 residents reviewed for unnecessary medication use. (Resident #108, Resident #137, Resident #43, Resident #98, Resident #94).</p> <p>Findings include:</p> <p>1. Resident #108's clinical record was reviewed on 8/11/2015 at 1:00 p.m. Diagnoses included, but were not limited to episodic mood disorder, dementia and depression.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 7/8/2015, assessed Resident #108 as taking an anti-psychotic medication the last 6 out of 7 days.</p> <p>Physician's order dated August 2015, indicated Resident #108's medications included, but were not limited to: Depakote Extended Release (an anti-convulsant used for mood disorder) 500 milligram tablet once a day. The original start date is unknown however, Resident #108 admitted to the facility on 3/6/2014, and was on the medication at that time. Depakote Extended Release 250 milligram tablet once a day with an</p>	F 0329	<p>1). <i>The corrective action taken for those residents found to be affected by the deficient practiceis that the resident identified asresident # 108 is now being monitored daily for targeted behaviors and theeffectiveness of the psychotropic medications in which they are currentlytaking.</i></p> <p>2). <i>The corrective action taken for those residents found to be affected by the deficient practiceis that the resident identified asresident # 137 is now being monitored daily for targeted behaviors and theeffectiveness of the psychotropic medications in which they are currentlytaking.</i></p> <p>3). <i>The corrective action taken for those residents found to be affected by the deficient practiceis that the resident identified asresident # 43 is now being monitored daily for targeted behaviors and theeffectiveness of the psychotropic medication in which the resident is currentlytaking.</i></p> <p>4). <i>The corrective action taken for those residents found to be affected by the deficient practiceis that the resident identified asresident # 98 is now being monitored daily for targeted behaviors and theeffectiveness of the psychotropic medications in which the resident iscurrently taking.</i></p> <p>5). <i>The corrective action taken for those residents found to be affected by the deficient practiceis that the resident identified asresident # 94 is now</i></p>	09/03/2015			

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	<p>original start date of 1/14/2015. The total daily dose of Depakote equaled 750 milligrams.</p> <p>Zyprexa (an anti-psychotic) 2.5 milligram tablet once every bedtime for behavioral mood disorder and depression. The original start date was 8/21/2014, with a discontinued date of 7/31/2015.</p> <p>A careplan initiated on 1/23/2015 with no documented goal date, for Resident #108 indicated a potential concern of: "... Zyprexa: dementia with behaviors and Depakote: mood ... observe for any mood or behavior changes and notify Social Services ..."</p> <p>The clinical record lacked documentation which indicated behaviors for which the medication was prescribed and the effectiveness of the medication were being monitored for Resident #108's Depakote and Zyprexa since her admit date of 3/6/2014.</p> <p>On 8/10/2015 at 10:24 a.m., an interview with Registered Nurse #2 (RN) indicated, they do not chart for behaviors. They are charting by exception if the resident has a behavior.</p> <p>On 8/11/2015 at 12:40 p.m., an interview with the Director of Nursing (DON)</p>		<p>being monitored daily for targeted behaviors and the effectiveness of the psychotropic medication in which the resident is currently taking. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been completed on all residents who currently take psychotropic medications. There clinical records have been up-dated to include the daily monitoring for targeted behaviors and the effectiveness of their current psychotropic medications.</i></p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised their policy on Psychotropic Drug Use, Monitoring and Reduction. The policy now includes the daily monitoring of targeted behaviors and monitoring for the effectiveness of the medications. A mandatory in-service has been conducted for all licensed nurses and QMAs on the changes in the facility policy. Special instruction was given related to the nurses and QMAs responsibility for documenting daily on targeted behaviors as well as documenting on the effectiveness of the psychotropic medications.</i></p> <p><i>The corrective action will be monitored to ensure the deficient</i></p>		

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	<p>indicated, they are not targeting for behaviors each day. If the resident has a behavior they will chart at that time.</p> <p>On 8/11/2015 at 11:00 a.m., the Administrator provided the facility's policy, "Psychotropic Drug Use, Monitoring and Reduction" dated 6/23/2014, and indicated the policy was the one currently being used by the facility. The policy did not address the daily monitoring and effectiveness of the medication for residents on a psychotropic medication.</p> <p>2. Resident #137's clinical record was reviewed on 8/11/2015 at 11:00 a.m. Diagnoses included, but were not limited to dementia, insomnia and depression.</p> <p>The comprehensive Minimum Data Set (MDS) assessment dated 4/30/2015, assessed Resident #137 as taking an anti-psychotic, an anti-anxiety, an anti-depressant and a hypnotic for 7 out of 7 days.</p> <p>Physician's order dated August 2015, indicated Resident #137's medications included, but were not limited to: Seroquel (an anti-psychotic) 200 milligram tablet twice a day for dementia with behavior disorder. The original start date was 4/23/2015.</p>		<p><i>practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool which will monitor for the daily documentation of targeted behaviors and the daily documentation of the effectiveness of psychotropic medications. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility regularly scheduled Quality Assurance Meetings to determine if any additional action is warranted.</i></p>	

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	<p>Rozerem (an hypnotic) 8 milligram tablet once a day at bedtime for insomnia. The original start date was 6/8/2015.</p> <p>Zoloft (an anti-depressant) 100 milligram tablet once a day for depression. The original start date was 4/23/2015.</p> <p>A careplan initiated on 5/12/2015, with no documented goal date, for Resident #137 indicated a potential concern of: "... Seroquel: dementia with psychosis ... observe for any mood or behavior changes and notify Social Services ..."</p> <p>A careplan initiated on 7/7/2015, with no documented goal date, for Resident #137 indicated a potential concern of: "... Rozerem for a diagnosis insomnia ... observe for any mood or behavior changes and notify Social Services ..."</p> <p>A careplan initiated on 5/12/2015, with no documented goal date, for Resident #137 indicated a potential concern of: "... Zoloft: depression ... observe for any mood or behavior changes and notify Social Services ..."</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, Black Box Warning for Zoloft include: "... Advise families and caregivers to</p>			

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	<p>closely observe patient for increasing suicidal thinking and behavior. ..."</p> <p>The clinical record lacked documentation which indicated behaviors for which the medication was prescribed and the effectiveness of the medication were being monitored for Resident #137's Seroquel, Rozerem and Zoloft since his admit date of 7/7/2014.</p> <p>On 8/10/2015 at 10:24 a.m., an interview with Registered Nurse #2 (RN) indicated, they do not chart for behaviors. They are charting by exception if the resident has a behavior.</p> <p>On 8/11/2015 at 12:40 p.m., an interview with the Director of Nursing (DON) indicated, they are not targeting for behaviors each day. If the resident has a behavior they will chart at that time.</p> <p>On 8/11/2015 at 11:00 a.m., the Administrator provided the facility's policy, "Psychotropic Drug Use, Monitoring and Reduction" dated 6/23/2014, and indicated the policy was the one currently being used by the facility. The policy did not address the daily monitoring and effectiveness of the medication for residents on a psychotropic medication.</p> <p>3. The clinical record was reviewed for</p>			

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	<p>Resident #43 on 8/11/15 at 11:31 a.m. The resident was admitted on 1/16/15. Diagnoses included, but were not limited to: dementia and depression.</p> <p>The physician's August 2015, orders for Resident #43 indicated the following:</p> <p>On 7/28/15, the resident was ordered Celexa (antidepressant medication) 20 mg (milligrams) daily.</p> <p>The clinical record lacked documentation which indicated targeted behaviors for which the medication was prescribed were monitored for Resident #43's Celexa.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for Celexa included: "... Monitor patient closely for worsening of depression or suicidal behavior..."</p> <p>8/10/15 at 10:24 a.m., RN #2 indicated the facility charts by exception regarding targeted behaviors and psychotropic medication use.</p> <p>During an interview, on 8/11/15 at 11:39 a.m., the DON (Director of Nursing) indicated if a resident displayed a behavior then staff would document the</p>			

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	<p>occurrence in the nursing notes.</p> <p>On 8/11/15 at 1:35 p.m., the Administrator provided the facility's policy, "Psychotropic Drug Use, Monitoring and Reduction," revised 6/23/14, and indicated it was the policy currently being used by the facility. The policy did not address monitoring for targeted behaviors related to psychotropic medication use.</p> <p>4. The clinical record was reviewed for Resident #98 on 8/11/15 at 1:21 p.m. The resident was admitted on 4/30/12. Diagnoses included, but were not limited to: dementia with behavioral disturbance and depression.</p> <p>The physician's August 2015, orders for Resident #98 indicated the following:</p> <p>On 4/14/15, the resident was ordered Risperidone (antipsychotic medication) 0.25 mg (milligrams) daily.</p> <p>On 1/27/15, the resident was ordered Prozac (antidepressant medication) 20 mg every morning.</p> <p>The clinical record lacked documentation which indicated targeted behaviors for which the medications were prescribed were monitored for Resident #98's</p>			

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	<p>Risperidone and Prozac.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for Prozac included: " ... Monitor patient closely for worsening of depression or suicidal behavior..."</p> <p>During an interview, on 8/11/15 at 11:39 a.m., the DON (Director of Nursing) indicated the facility charts behaviors by exception and if a resident displayed a behavior then staff would document the occurrence in the nursing notes.</p> <p>On 8/11/15 at 1:35 p.m., the Administrator provided the facility's policy, "Psychotropic Drug Use, Monitoring and Reduction," revised 6/23/14, and indicated it was the policy currently being used by the facility. The policy did not address monitoring for targeted behaviors related to psychotropic medication use.</p> <p>5). Resident #94's clinical record was reviewed on 8/12/15 at 11:03 a.m. Diagnoses included, but were not limited to: depression.</p> <p>The current quarterly MDS (Minimum Data Set) assessment dated 6/26/15, Resident #94 had a active diagnosis of depression.</p>			
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	<p>Physician's order dated 8/1 through 8/31/2015, indicated Resident #94 received Cymbalta 60 mg (milligram) daily for depression since 6/9/15.</p> <p>The current care plan "Anti-Depressant" dated 7/14/15, indicated "...takes the psychotropic medications: Cymbalta...DX [diagnoses] : Change in mental status and mood, ...GOAL: ...will be free from adverse reactions and side effects of medication, ...INTERVENTIONS: ... 2. Be aware of an observe for side effects of medication, ...4. Observe for any mood or behavior changes and notify Social Services, 5. Psych Care PRN [as needed] ... Side Effects ..."</p> <p>The clinical record lacked documentation which indicated targeted behaviors for which the medication was prescribed were monitored for Resident #94's Cymbalta.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for Cymbalta (antidepressant), monitor for signs of suicidal behaviors, worsening depression [such as agitation, irritability, insomnia, hostility].</p>			

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F 0431 SS=D Bldg. 00	<p>On 8/10/15 at 10:24 a.m., RN #2 indicated the facility charts by exception regarding targeted behaviors and psychotropic medication use.</p> <p>On 8/11/15 at 11:39 a.m., the DON (Director of Nursing) indicated the facility charts behaviors by exception and if a resident displayed a behavior then staff would be document the occurrence in the nursing notes.</p> <p>On 8/11/15 at 1:35 p.m., the Administrator provided the facility's policy, "Psychotropic Drug Use, Monitoring and Reduction," revised 6/23/14, and indicated it was the policy currently being used by the facility. The policy did not address monitoring for targeted behaviors related to psychotropic medication use.</p> <p>3.1-48(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of</p>			

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	<p>all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the refrigerator which stored medications in the medication rooms behind the 500 hall's nursing station maintained the proper temperature for 1 of 3 medication refrigerators observed during medication storage.</p> <p>Findings include: On 8/11/15 at 9:32 a.m., with RN #3</p>	F 0431	<p><i>The corrective action taken for those residents found to be affected by the deficient practice is that no residents were identified however all residents on the 500 unit could be affected by the deficient practice. That refrigerator has been cleaned is maintaining the temperatures of between 45 – 35 degrees Fahrenheit.</i></p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of all medication storage refrigerators</i></p>	09/03/2015

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	<p>present observed the medication storage room, behind the nursing station on the 500 hall, refrigerator to have a temperature of 48 degrees Fahrenheit.</p> <p>Review of the "CLEANING SCHEDULE" form dated August 2015, indicated on 8/8/15, and 8/10/15, the medication refrigerator temperatures were 48 degrees Fahrenheit.</p> <p>On 8/11/15 at 135 p.m., the Administrator provided policy "Refrigerator Storage and Cleanliness" dated 10/24/06, and indicated the policy was the one currently used by the facility. The policy indicated, "...All refrigerators allocated for Medication storage will: 1. Have a temperature log and will be recorded daily. 2. Temperatures will not exceed 45 degrees Fahrenheit or be lower than 35 degrees Fahrenheit. ..."</p> <p>3.1-25(m)</p>		<p>has been completed and all other medication storage refrigerators are maintaining the proper temperatures of 45 – 35 degrees Fahrenheit.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice <i>does not recur is that</i> a mandatory in-service has been conducted for all licensed nurses and QMA on their responsibility to monitor the medication storage refrigerator temperatures daily and the proper procedure of reporting any abnormal temperatures to the maintenance department immediately so that the problem can be corrected timely.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance Tool to monitor the temperatures of the medication storage refrigerators. This tool will be completed by the Director of Environmental Services and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility regularly scheduled Quality Assurance Meetings to determine if any additional action is warranted.</i></p>	

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F 0441 SS=D Bldg. 00	<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 observation, interview, and record review, the facility failed to ensure</p>	F 0441	1). <i>The corrective action taken for thoseresidents found to be</i>	09/03/2015	

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	<p>infection control practices were followed related to hand washing and glove use during patient care as indicated by the facility policy for 1 of 1 randomly observed resident during stage 2 (Resident #99), touching a resident's medication with bare hands (Resident #100), cleaning of the facility thermometer after dropping it on the floor and handwashing for 20 seconds as indicated by the facility policy and Center for Disease Control guidelines (Resident #179, Resident #181).</p> <p>Finding includes</p> <p>1). On 8/11/15 at 11:15 a.m., CNA #1 and CNA #2 were observed to provide activity of daily living care for Resident #99. CNA #1 was observed to place on gloves and removed the soiled fitted sheet and pad from under the left side of Resident #99. Resident #99's bed was observed to be soaked with urine. CNA #1 was observed with the dirty gloves on to place clean linen on the left side of the bed and spread over the urine on the mattress. CNA #1 was observed to remove gloves, walk into the bathroom and handwash. CNA #1 was observed to place clean gloves on and wipe the urine off the mattress with a clean towel and proceeded to place the contaminated linen on the bed. CNA #1 indicated she</p>		<p><i>affected by the deficient practice is that the resident identified as resident # 99 is now receiving incontinent care and is having their soiled bed linens changed in accordance with acceptable standards of infection control practices. 2). The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #100 is now receiving their blood pressure check by staff members that are washing their hands for twenty seconds in accordance with facility policy. 3). The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 100 is now receiving their medications in accordance with acceptable standards of practice related to the proper removal of medications from the blister packs, proper handwashing for twenty seconds and the proper use of gloves. 4). The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as resident # 180 and resident # 179 is now having their temperatures taken with equipment that has been appropriately sanitized. 5). The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as residents # 181 and # 179 are</i></p>				

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	<p>should have changed gloves and cleaned the soiled mattress before placing clean linen on the bed. CNA #1 was observed to remove soiled linen and place in a plastic bag. CNA #1 removed soiled gloves at that time and handwashed. CNA #1 applied clean gloves and linen on the left side of the bed. CNA #2 was observed to wipe the right side of Resident #99's bed. Resident #99 began to urinate. CNA #2 was observed with gloves on to wipe the urine off Resident #99 and with the soiled gloves on pushed Resident #99 on his left side. CNA #2 indicated she was not aware she needed to change her gloves at that time. CNA #2 was observed to remove the soiled gloves and enter the bathroom to handwash.</p> <p>2). On 8/10/15 at 9:06 a.m., LPN #1 was observed to on enter Resident #100's room no hand washing was observed, walked over to Resident #100 and obtain blood pressure reading. LPN #1 walked into the bathroom and handwash for 10 seconds after taking Resident #100's blood pressure.</p> <p>3). On 8/10/15 at 9:23 a.m., observed LPN #1 to touch Resident #100's medication with her hands while popping the pills out of the medication card. LPN #1 was observed to use hand sanitizer</p>		<p>now receiving their medications by a licensed nurse and/or QMA who is demonstrating acceptable standards of infection control practices related to medication administration and handwashing practices. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by these deficient practices. All residents are now receiving resident care including the administration of medication in accordance with acceptable standards of infection control practices. The residents are also receiving services with the use of equipment, including thermometers that have been properly sanitized prior to use. The residents are receiving services by nursing staff members who have properly sanitized their hands and are utilizing gloves in accordance with acceptable standards of infection control practices. <i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all nursing staff on the facility's infection control practices. This in-service included the proper use of handwashing and glove usage when; changing a soiled resident, disinfecting a soiled mattress,</i></i></p>		

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	<p>afterwards. LPN #1 indicated she should not have touched Resident #100's medication with her hands. LPN #1 entered Resident #100's room and administered medications. LPN #1 placed on gloves and administered nasal spray. LPN #1 was observed to handwash for 5 seconds place on clean gloves and remove a pain patch and place a new patch on. LPN #1 entered the bathroom, removed gloves and handwashed for 5 seconds and exited the room. LPN #1 indicated she should handwash for 20 seconds and not sure how to determine 20 seconds was being done.</p> <p>4). On 8/11/15 at 8:50 a.m., observed CNA #3 getting vital signs on Resident #180. The thermometer was observed to fall on the floor. CNA #3 was observed to pick up the thermometer and place on the nursing stations counter. No sanitizing of the thermometer was observed at that time. CNA #3 was observed to enter Resident #179's room to get Resident #179's vital signs. CNA #3 indicated she should have sanitized the thermometer after it fell on the floor.</p> <p>5). On 8/11/15 at 8:35 a.m., RN #1 was observed to enter Resident #181's room to administer medication and handwashed for 13 seconds. RN #1</p>		<p>applying clean linens to a resident's bed, checking bloodpressures, sanitation of soiled thermometers and medication administration. <i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance Tool to the proper application of infection control practices related to changing a soiled resident, disinfecting a soiled mattress, applying clean linens to a resident's bed, checking blood pressures, sanitation of soiled thermometers and medication administration. This tool will be completed by the Director of Nursing and/or their designee. This tool will be completed every shift for seven days, then weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility regularly scheduled Quality Assurance Meetings to determine if any additional action is warranted.</i></p>		

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	<p>walked to the medication cart and dispensed Resident #179's medication. RN #1 was observed to scratch her face while dispensing medication into the medication cup. No hand washing nor hand sanitizer use was observed at that time. RN #1 was observed to take Resident #179's medication to the therapy room to located Resident #179. Resident #179 was not in therapy so RN #1 was observed to walk to the medication cart, rub her neck and lift her hair. No handwashing was observed. RN #1 walked into Resident #179's room no handwashing was observed before administering medication and RN #1 was observed to handwash for 20 seconds. RN #1 indicated she should have handwashed when entering and exiting rooms, whenever you do anything for residents. RN #1 indicated she should have handwash after touching herself.</p> <p>On 8/13/15, review of Center for Disease Control at www.cdc.gov/handwashing/, dated December 16, 2013 indicated, "When should you wash your hands? ...Before and after caring for someone who is sick, ...After touching garbage, ... How should you wash your hands?Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. ... "</p>			

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	<p>On 8/11/15 at 1:35 p.m., the Administrator provided policy "Hand Washing" dated 5/28/14, and indicated the policy was the one currently used by the facility. The policy indicated, " ...1. Every employee will cleanse their hands before and after every resident care encounter. 2. ... hand cleansing will occur after removal of gloves. ... If hand washing is accomplished with soap ... the following procedure will continue to be used: ...1. Hand cleansing will occur before and after every resident care encounter. 3. ... The lathering process should take at least twenty[20] seconds ..."</p> <p>3.1-18(I)</p>			