

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2013
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NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 4, 5, 6, 7, and 8, 2013</p> <p>Facility number: 000571 Provider number: 155374 Aim number: 100266920</p> <p>Survey team: Donna M. Smith, RN-TC Susie Worsham, RN Cheryl Mabry, RN Bobette Messman, RN Diana McDonald, RN Julie Baumgartner, RN</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 10 Medicaid: 16 Other: 6 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on</p>	F0000	<p>F000</p> <p>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 requests that this plan of corrections be considered our allegation of compliance effective March 1, 2013 to the state findings of the Recertification and State Licensure QIS Survey conducted February 4 th -February 8 th , 2013.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	February 17, 2013; by Kimberly Perigo, RN.			

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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation and interview, the facility failed to ensure pertinent State client advocacy groups, their addresses, and their telephone numbers were posted at eye level for wheelchair residents for 3 of 5 days observed during the survey. (2/4/13, 2/6/13, and 2/7/13)</p> <p>Findings include:</p> <p>On 2/4/13 at 9:10 a.m., upon entry to the facility the State client advocacy groups information was observed next to the Administrator's office doorway at standing eye level.</p> <p>On 2/6/13 at 9:00 a.m., during the Resident Council interview Resident #25 indicated she was not aware of the location of the State client advocacy groups information.</p>	F0156	<p>F156</p> <p>It is the intent of this facility to inform all residents of his/her rights, all rules, and regulations governing resident conduct and responsibilities during their stay in the facility. All residents have the potential to be affected. <i>The corrective action taken for those residents found to be affected by or potentially affected by the deficient practice is relocation of the facility information- including State Survey information and certification, State Licensure offices, State Ombudsman program, Medicare/Medicaid information, and statement that a resident may file a complaint with the ISDH and Certification Agency including addresses and phone numbers of such entities to wheelchair eye level. Additional measures or systemic changes that have been put into place to ensure that the deficient</i></p>	03/06/2013

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	<p>On 2/7/13 at 10:22 a.m., Resident #25 was observed to be passing by the Administrator's office in her wheelchair. At that same time with the Administrator present, Resident #25 indicated not being able to see the framed State client advocacy groups information as the information was located too high on the wall.</p> <p>3.1-(j)(3)(A) 3.1-(j)(3)(B) 3.1-(j)(3)(C) 3.1-(j)(3)(D) 3.1-(j)(3)(E) 3.1-(j)(3)(F) 3.1-(j)(3)(G)</p>		<p><i>practice does not recur is that all residents will be informed of rights with written copy of such and signature of receipt of document. Admission process will also offer verbal explanation of resident rights with signature required to verify understanding. The facility will also review resident rights and location of aforementioned information and identity of Ombudsman with each monthly Resident Council meeting. Documentation of such will be retained in the Resident Council Meeting minutes.</i></p> <p>Completion Date: 3/6/2013</p>		

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F0176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were assessed for self medication administration for 2 of 2 randomly observed residents (Resident #28 and #47) and for 1 of 19 residents observed (Resident #43) during medication administration observation.</p> <p>Findings include:</p> <p>1. On 2/4/13 at 11:42 a.m., Resident #28 was observed receiving a masked nebulizer treatment. No nursing staff was observed. Also, a Ventolin inhaler (bronchodilator) was observed in the resident's wheelchair. At that time, Resident #28 indicated the Ventolin inhaler was for his personal usage, which he used occasionally.</p> <p>On 2/4/13 at 2:30 p.m., during an interview Resident #28 indicated nursing staff did not stay with him during his nebulizer treatments. He also indicated when he used his inhaler, he would let the nursing</p>	F0176	<p>F176 It is the intent of this facility to allow self-administration of medication if the interdisciplinary team has determined that this practice is safe. All residents with an order "may keep at bedside" medications/treatments have potential to be affected. <i>The corrective action taken for all residents having the potential to be affected by the same deficient practice is a 100% facility-wide audit for all MKAB medications with assessments for safe self-administration of medications completed and physician's order obtained that specifies that the resident is deemed safe to self-administer such medication(s).</i></p> <p><i>Additional measures or systemic changes that have been put into place to ensure that the deficient practice does not recur are that licensed nursing staff will be in serviced on providing education on self-administration of medications/treatments and documentation of education provided. All assessments for self-administration of medications/treatments will be reviewed quarterly and with condition changes. A quality</i></p>	03/06/2013

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	<p><b>staff know.</b></p> <p><b>Resident #28's clinical record was reviewed on 2/4/2013 at 4:00 p.m. The quarterly Minimum Data Set assessment, dated 12/20/12, indicated a BIMS (Basic Interview Mental Status)'s score of 15; with a score of 8 to 15 as interviewable. No information was indicated related to an assessment for self medication administration, physician's order to allow the resident to self medicate, nor for the Ventolin inhaler.</b></p> <p><b>2. On 2/5/13 at 10:41 a.m., Resident #47 was observed with eye drop medications. At that time, Resident #47 indicated he was administering his own eye drops due to the nursing staff would not help him with the eye drops because the eye drops were not listed on his medication sheet.</b></p> <p><b>Resident #47's record was reviewed on 2/5/13 at 11 a.m. No information was indicated related to self medication data form and assessment completed nor a physician's order.</b></p> <p><b>On 2/8/13 at 1:48 p.m., during an</b></p>		<p><i>assurance tool has been developed and implemented to monitor all new admissions for may keep at bedside orders with appropriate assessments completed and physician's orders obtained and audit of nursing staff providing education to residents with self-administered medications/treatments. These audits will be performed by the D.O.N. or designee 3 times a week x 1 week; then 2times a week x 1 week; then weekly with results taken to the next quarterly Q.A. meeting to determine if additional intervention is warranted as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions</i></p> <p><i>Completion Date: 3/6/2013</i></p>				

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	<p><b>interview LPN #28 indicated if a resident had an order for MKAB (may keep at bedside), the resident should also have a self medication data form and assessment completed related to the medication(s).</b></p> <p><b>On 2/8/13 at 3:00 p.m., the facility's current policy and procedure for self medication administration indicated bedside storage of medications was permitted with a self medication administration data collection and assessment completed for a resident.</b></p> <p>3. On 2/5/13 at 8:23 a.m., medication pass was observed. After preparing Resident #43's medications, RN #24 set the resident's respiratory medications on his bedside table. Resident #43 was observed to take his respiratory medications of Serevent (bronchodilator), Pulmocort inhaler (anti-inflammatory/anti-asthmatic), Spiriva (bronchodilator) and followed by Fluticasone Prop (Flonase) (anti-inflammatory) nasal spray. No instructions related to the sequence of respiratory medications and a waiting period or rinsing out his mouth between the respiratory medications</p>			

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	<p>were given by this nurse during this observation.</p> <p>Resident #43's record was reviewed on 2/8/13 at 9:20 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, sleep apnea and pneumonia. No physician order nor assessment was indicated for the resident to self administer his medications.</p> <p>3.1-11(a)</p>			

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F0223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident's call light was in reach to summon for help for 1 of 4 residents reviewed for abuse in a sample of 4. (Resident #46)</p> <p>Findings include:</p> <p>1. On 2/5/13 at 11:19 a.m., during Interview Resident #46 indicated RN #1 was rough with her. She also indicated she had called her husband last night at 11:30 p.m., because she was in pain and could not get to the call light string to call the nurse. She indicated that her husband came in at that time. Interview with Resident # 46's husband on 2/5/13 indicated when he arrived he observed the call light clipped to the wall and her bed control on the floor. Her husband felt they may have given her medications to make her sleep, put her in the position they wanted, and took her call light away.</p>	F0223	<p>F223 F 226 It is the intent of the facility to ensure that the residents have the right to be free from verbal, physical, sexual, mental abuse, corporal punishment and involuntary seclusion. Residents #29, #46, and #14 were allegedly affected with all residents having the potential to be affected. The corrective action taken for the same deficient practice is that investigation of all allegations for residents #29, #46, and #14 with appropriate reports sent to ISDH. All staff members were inserviced on abuse beginning during survey on Feb 4 th through Feb 8, 2013. <i>The measures or systemic changes that have been put into place to ensure that the deficient practice does not occur is that Administrative Nursing Staff have been inserviced to continue to adhere to ISDH requirements to report any abuse allegations within 24 hours of receiving notification of such and investigation to be immediately initiated. All new employees will continue to have Abuse</i></p>	03/06/2013	

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	<p>On 2/8/13 at 8:45 a.m., during an interview the DON (Director of Nurses) indicated when the administrative staff left for the day, the nurses were responsible to check each patients call light frequently and was part of their duties during their shifts.</p> <p>2. The current facility's "ABUSE" policy and procedure was provided by the Administrator on 2/6/13 at 9:33 am. This current policy indicated the following:</p> <p>"POLICY: This facility shall observe the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment and involuntary seclusion.</p> <p>Resident Abuse Resident abuse is defined as any action which may cause a resident to suffer from discomfort, fear, or embarrassment. Examples of abuse are as follows, but are not inclusive: Mental Abuse 1. Taking call light cord away from resident or leaving it out of resident's reach... Neglect</p>		<p><i>inservicing on hire. Abuse inservicing will continue on a monthly basis reviewing facility policy to include identification and immediate notification of Administrator and immediate reporting of such until next quarterly Q.A. including review of facility policy that the Administrator must be notified immediately of any abuse or allegation of abuse. Staff inservice on call light placement will be completed and Q.A. monitoring tool implemented to monitor call light placement and will be completed by nurses every shift dailyx1week; then 4x/wk x1week(S/Tu/Th/Sat); then 3x/wk x 1week (M-W-F) then 2x/wk; random times over 24 hour period for completion of monitoring tool. Results of monitoring tool will be reviewed at next quarterly Q.A. to determine if additional interventions are warranted as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions. All reports to ISDH will be reviewed for compliance with 24 hour reporting window with 100% accuracy required. IDR of this tag has been requested due to inaccurate reflection of event on 2567. Completion Date: 3/6/2013</i></p>		

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	<p>1. Failure to assist a resident when such failure could negatively affect the health, safety, or welfare of the resident....."</p> <p>3.1-27(a)(3)</p>			

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F0226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to report alleged abuse immediately to the Administrator and within 24 hours to the Indiana State Department of Health for 3 of 4 residents reviewed for abuse in a sample of 4. (Resident #14, #46, and #29)</p> <p>Findings include:</p> <p>1. On 2/4/13 at 3:00 p.m., during a written interview of the Stage 1 questions, Resident #29, who was hard of hearing, indicated she had been treated roughly by the staff when being put to bed and felt staff did not treat her with respect or dignity.</p> <p>On 2/7/13 at 10:15 a.m., during a second written interview with Resident #29, she indicated nursing staff was rough when they were changing her for bed, as they seemed to be in too big of a hurry.</p>	F0226	<p>F223 F 226 It is the intent of the facility to ensure that the residents have the right to be free from verbal, physical, sexual, mental abuse, corporal punishment and involuntary seclusion. Residents #29, #46, and #14 were allegedly affected with all residents having the potential to be affected. The corrective action taken for the same deficient practice is that investigation of all allegations for residents #29, #46, and #14 with appropriate reports sent to ISDH. All staff members were inserviced on abuse beginning during survey on Feb 4 th through Feb 8, 2013.</p> <p><i>The measures or systemic changes that have been put into place to ensure that the deficient practice does not occur is that Administrative Nursing Staff have been inserviced to continue to adhere to ISDH requirements to report any abuse allegations within 24 hours of receiving notification of such and investigation to be immediately initiated. All new employees will continue to have Abuse inservicing on hire. Abuse inservicing will continue on a monthly basis reviewing facility policy to include</i></p>	03/06/2013	

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	2. On 2/5/13 at 11:19 a.m., during an interview Resident #46 indicated RN #1 was rough with her. She also indicated she had called her husband last night at 11:30 p.m., because she was in pain and could not get to the call light string to call		<p><i>identification and immediate notification of Administrator and immediate reporting of such until next quarterly Q.A. including review of facility policy that the Administrator must be notified immediately of any abuse or allegation of abuse. Staff inservice on call light placement will be completed and Q.A. monitoring tool implemented to monitor call light placement and will be completed by nurses every shift dailyx1week; then 4x/wk x1week(S/Tu/Th/Sat); then 3x/wk x 1week (M-W-F) then 2x/wk; random times over 24 hour period for completion of monitoring tool. Results of monitoring tool will be reviewed at next quarterly Q.A. to determine if additional interventions are warranted as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions. All reports to ISDH will be reviewed for compliance with 24 hour reporting window with 100% accuracy required.</i></p> <p><i>Completion Date: 3/6/2013</i> <i>Completion Date: 3/6/2013</i> <i>Reason for IDR request- tag does not accurately reflect what occurred.</i></p>		

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	<p>the nurse. She indicated that her husband came in at that time. Interview with Resident # 46's husband on 2/5/13 indicated when he arrived he observed the call light clipped to the wall and her bed control on the floor. Her husband felt they may have given her medications to make her sleep, put her in the position they wanted, and took her call light away.</p> <p>On 2/8/13 at 8:45 a.m., during an interview the DON (Director of Nurses) indicated when the administrative staff left for the day, the nurses were responsible to check each patients call light frequently and was part of their duties during their shifts.</p> <p>3. On 02/04/13 at 2:43 p.m., during an interview, Resident #14 indicated she was afraid of the night nurse. Resident #14 indicated she had told the nursing staff who indicated she was not the first one.</p> <p>Per written message, dated 2/3/13, addressed to the Director of Nursing, CNA #29 indicated Resident #14 had approached her expressing her fear with the nurse assigned to her unit because she "was scared" of her.</p> <p>4. On 2/6/13 at 8:55 a.m., during an interview, the Administrator indicated she had not informed the Indiana State</p>			

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	<p>Department of Health related to the alleged mistreatments reported to her 2/5/12 related to Resident #46 and #14.</p> <p>The three following "Indiana State Department of Health Division (ISDH) of Long Term Care - Incident Report Form" were provided by the Administrator on 2/8/13 at 9:10 a.m. by the Administrator. These reports indicated the following:</p> <p>Resident #29's alleged mistreatment was on 2/4/13 and was reported to ISDH on 2/6/13;</p> <p>Resident #46's alleged mistreatment was on 2/4/13 at 11:40 p.m. and was reported to ISDH on 2/6/13;</p> <p>Resident #14's alleged mistreatment was on 2/3/13 at 8:45 p.m. and was reported to ISDH on 2/6/13.</p> <p>5. The current facility's "ABUSE" policy and procedure was provided by the Administrator on 2/6/13 at 9:33 am. This current policy indicated the following:</p> <p>"POLICY: This facility shall observe the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment and involuntary seclusion.</p> <p>Resident Abuse</p>						

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	<p>Resident abuse is defined as any action which may cause a resident to suffer from discomfort, fear, or embarrassment. Examples of abuse are as follows, but are not inclusive:</p> <p>Mental Abuse</p> <p>1. Taking call light cord away from resident or leaving it out of resident's reach...</p> <p>Neglect</p> <p>1. Failure to assist a resident when such failure could negatively affect the health, safety, or welfare of the resident....."</p> <p>"INVESTIGATION OF ABUSE ALLEGATIONS</p> <p>1. Any allegation(s) of abuse will be immediately reported to the Administrator and handled promptly and thoroughly investigated.</p> <p>...8. All alleged abuse situations shall be reported to ISDH within 24 hours of notification of such to administration....."</p> <p>3.1-28(a)</p>				



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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's dignity was maintained related to personal care and availability of bathroom facilities for 1 of 4 residents reviewed for dignity in a sample of 4. (Resident #14)</p> <p>Findings include:</p> <p>1. On 02/04/12 at 2:34 p.m., during an interview Resident #14 indicated she recently had found her bathroom door to be locked. She indicated she was unable to get any help, which resulted in incontinent episodes. She also indicated the resident sharing the bathroom with her left her toilet assistance device over the toilet, which she had to remove before she could use the toilet.</p> <p>Resident #14's record was reviewed on 2/8/13 at 9:30 a.m. The nurse's notes indicated the resident had been worrisome about her bathroom door being locked on 2/5/13 with no further</p>	F0241	<p>F241</p> <p>It is the intent of this facility to promote care for the residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. All residents who share a bathroom with another resident have the potential to be affected. Resident #14 is no longer at the facility.</p> <p><i>The corrective action taken for all residents with the potential to be affected by the same deficient practice is that staff will be inserviced on unlocking bathroom doors after completion of bathroom use. Reminder signs will be available for application for any residential complaints or requests.</i></p> <p><i>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a Q.A. tool has been developed and implemented to ensure that bathroom doors are unlocked after use and will be completed by the D.O.N. or designee daily X1week then 3 times a week x 1 week then weekly. Results of the Q.A. monitoring tool will be reviewed at the next quarterly Q.A.</i></p>	03/06/2013	

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	information indicated.  3.1-3(t)		<i>to determine if additional interventions are required. Completion Date: 3/6/2013</i>	

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician orders for medications for 1 of 10 residents reviewed (Resident #5) for unnecessary medications and to follow the care plan related to hands splint and call light positioning (Resident #1) for 1 of 31 residents reviewed.</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 2/6/13 at 10:18 a.m. The resident's diagnoses included, but were not limited to, bladder spasms, HTN (Hypertension), TIA (Transient ischemic attack ), diabetes mellitus Type II, depression/anxiety, and dementia.</p> <p>The physician's order, dated 3/23/10, was Ferrous Sulfate 325 mg (milligrams) (iron supplement), give one tablet orally once a day.</p> <p>The physician's order, dated 3/23/10, was Colace 100 mg (milligrams) (stool softener) BID (twice daily) while taking the medication, Ferrous</p>	F0282	<p>F282 It is the intent of this facility to have services provided or arranged by qualified persons in accordance with each resident's written plan of care. <i>The corrective action taken for those residents found to be affected by the deficient practice is that the call light system for resident #1 has been augmented with an attached plastic loop to accommodate decreased function of the resident's left upper extremity. The corresponding siderail on the resident's bed has been marked with a red stripe to serve as a visual cue and reminder to staff to place the call light on that side of the patient. The therapy department was enlisted to clarify the splint discrepancy and the careplan has been corrected/clarified. Implementation of new orders review by night shift nurses to verify all physician orders with MAR's and TAR's to check for transcription errors.</i></p> <p><i>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that nursing staff will be inserviced on appropriate and proper splint application and</i></p>	03/06/2013			

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	<p><b>Sulfate.</b> The physician's order, dated 12/4/12, was to discontinue Ferrous Sulfate.</p> <p>The December 2012 and January, 2013 through February 4, 2013 MAR's (medication administration record) indicated the resident had received the Colace medication twice daily.</p> <p>The bowel and bladder records for January, 2013 through February 4, 2013, indicated Resident #5 had loose stools for 3 of the 6 days in February and for 5 of 31 days in January.</p> <p>On 2/7/13 at 5:00 p.m., during an interview the Director of Nursing indicated she was unaware of Resident #5's order related to discontinuing the Colace when the Ferrous Sulfate had been discontinued. She indicated the physician's order should have been followed.</p> <p>2. On 2/4/13 at 12:49 p.m., Resident #1 was observed in the bed with the call light on night stand, out of reach and no splint on his right arm and a splint on his left arm. The right arm was not elevated also. There was a splint on his left arm. During a second observation at 2:45 p.m., there</p>		<p><i>placement of call light to ensure that the call light is in reach. A Q.A. monitoring tool has been developed and implemented to check appropriate splint placement. This tool will be completed by D.O.N. or designee 5x/wk x1week; then 3x/wk x1week; then 2x/wk with results taken to the next Q.A. to determine if additional interventions are warranted. Additional Q.A. monitoring tool developed and implemented for call light placement. Call light monitoring tool to be completed by D.O.N. or designee every shift daily x1week; then 4x/wk x1week (S/Tu/Th/Sat); then 3x/wk x 1week (M-W-F) then 2x/wk. Results of monitoring tool will be reviewed at next quarterly Q.A. to determine if additional interventions are warranted as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions .</i></p> <p><i>Completion Date: 3/6/2013</i></p>				

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	<p>was no change with Resident #1's positioning nor his call light.</p> <p>On 2/5/13 at 1:43 p.m., Resident #1 was observed in his gerichair in his room and indicated he had been in his chair for a long time and wanted to go to bed. The call light was observed attached to the left side of his blanket, out of reach. CNA #5 and CNA #25 were informed of Resident #1's discomfort at that time.</p> <p>On 2/6/13 at 9:00 a.m., Resident #1 was observed in his bed without a splint on his right hand and not elevated. The left hand had a splint on it. The call light was observed on the night stand at that time, out of reach.</p> <p>On 2/6/13 at 3:00 p.m., Resident #1's splint was observed not in place. Also, his call light was attached to the padding on the left side of his bed. At that time, Resident #1 indicated he could not reach the call light when it was positioned on his left side. He indicated he knew how to use the call light, and it should be positioned on his right side for him to be able to pull the string to activate it.</p> <p>On 2/7/13 at 8:20 a.m., Resident #1 was observed in his room in his gerichair, and the call light was observed clipped to his mattress out of his reach.</p>						

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	<p>On 2/7/13 at 8:25 a.m., LPN #3 was informed of the location of Resident #1's call light, and she indicated the positioning of the call light was not correct for him to reach it.</p> <p>On 2/7/13 at 10:35 a.m., Resident #1 was observed to remain in his gerichair with the call light attached to a blanket on his left side.</p> <p>Resident #1's record was reviewed on 2/6/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, traumatic brain injury and hemiplegia. The quarterly Minimum Data Set assessment, dated 12/21/12, indicated a Basic Interview Mental Status (BIMS) score of 14 with a score of 8 to 15 as interviewable. The resident was totally dependent with 2 assists for activities of daily living (ADL's) with impairment on both upper and lower extremities. The physician's order, dated 12/4/12, indicated Resident #1 was to wear a splint at all times when in bed on the right and the left hand; nurse to check every 2 hours for adverse reactions to the splints. No information was indicated a splint was being placed on the resident's left or right hand with no observations of a right hand splint being used.</p>			
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	<p>On 2/7/13 at 11:11 a.m., during an interview Restorative Aide #7 indicated Resident #1 was to wear a left hand brace at all times while in bed.</p> <p>3.1-35(g)(2)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, interview, and observation, the facility failed to ensure the safety of residents while being transferred with the assistance of a mechanical lift in the prevention of accidents for 1 of 3 residents observed during a mechanical lift transfer. (Resident #29)</p> <p>Findings include:</p> <p>1. On 2/7/13 at 11:23 a.m., Resident #29's transfer with a stand-aide lift (Apexlift Stella Stand Assist Lift) was observed. CNA #3 and CNA #6 were observed to place the lift sling under Resident #29's arms and attach the sling to the lift. The lift was positioned placing the resident's feet on the foot rest of the stand-aide, but with no attempt to place her knees up against the kneepad of the lift. The CNA's then instructed her to hold onto the bar as they lifted her from her wheelchair. The resident was observed hanging from the arm bar with her knees away from kneepad in</p>	F0323	<p>F323 It is the intent of this facility to ensure that the resident's environment remains free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. <i>The corrective action for those residents to be found affected by the alleged deficient practice is that resident #29 who remains in the facility has been evaluated for transfers using the stand aid and therapy indicates that the stand aid remains the safest and most appropriate means for transferring this patient while maintaining optimal resident function. All other residents using the stand aid for transfers and have potential to be affected. The measures or systemic changes that have been put into place to ensure that the alleged deficient practice does not occur is that an inservice for stand-aid transfers will be given for all nursing staff per therapy department. A Q.A. tool has been developed and implemented to monitor stand aid transfers and will be monitored per D.O.N. or designee for safety and appropriate use of assistive device 3x/wk x 2 weeks;</i></p>	03/06/2013			

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	<p>an outward arched position as she was transferred from her wheelchair in the room to the toilet in the bathroom. After she was finished, Resident #29 was observed to be transferred from the bathroom back to her wheelchair hanging from the arm bar in an arched position without her knees touching the kneepad of the lift. At that time CNA #6 indicated she did not think the resident was in a standing position, while in the stand-aide and may need to be reevaluated for the lift. CNA #6 indicated she would tell the nurse.</p> <p>Resident #29's record was reviewed on 2/8/13 at 8:33 a.m. The resident's diagnoses included, but were not limited to, diabetic mellitus and arthritis. The physician's order, dated 1/24/13, was for clarification to discontinue the mechanical lift for transfers and to transfer the resident per stand-aide lift.</p> <p>The Apexlift Stella Stand Assist Lift information pamphlet was provided by the Administrator on 2/7/13 at 3:10 p.m. This information indicated the resident must be able to bear weight and in the section "Lift and transfer from wheelchair" #3 "Position patient's feet on the foot platform and knees against the knee pad" #7</p>		<p>then 2x/wk x 2 weeks; then weekly with random times over 24 hour period of monitoring completion with results reviewed at next Q.A. to determine if further interventions required as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions. Completion Date: 3/6/2013 IDR requested due to tag given does not accurately reflect what occurred.</p>				

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	<p>"Before the patient's body is lifted from the chair, stop and make(s) sure the sling is secured and patient's knees are against the knee pad."</p> <p>On 2/8/13 at 9:25 a.m., during an interview Occupational Therapist #15 indicated although the knee board on the stand-aid lift was there, she felt most people couldn't reach it with their knees because they were too little. She also indicated the kneepad was there in case their knees buckled.</p> <p>3.1-45(a)(2)</p>			

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 19 residents observed for 3 of 4 nursing staff observed during medication pass. The medication error rate was 11.53%. (Resident #10, #21, and #43 ) (RN #2, RN #24, and LPN #26)</p> <p>Findings include:</p> <p>1. On 2/5/13 at 8:23 a.m., medication pass was observed. After preparing Resident #43's medications, RN #24 set the resident's respiratory medications on his bedside table. After taking his oral medications (meds) and his Serevent, Resident #43 was observed to take his Pulmocort inhaler (anti-inflammatory/anti-asthmatic) without rinsing his mouth out after use. After waiting for 32 seconds, he then took one inhalation of his Spiriva (bronchodilator) with no rinsing of his mouth after its use. As RN #24 collected his respiratory medications from the bedside table, she realized</p>	F0332	<p>F332 It is the intent of this facility to be free of medication error rates of 5% or greater. <i>All residents of the facility have the potential to be affected. The corrective action taken for the same deficient practice is that licensed nurses will be inserviced on correct administration of inhalers, eye drops, and nasal sprays. Inservicing on the nurse's role in assisting residents who self administer medications completed and appropriate documentation of education given.</i></p> <p><i>The measures and systemic changes put into place to ensure that the deficient practice does not recur is that a Q.A. monitoring tool has been developed and implemented to monitor eye drops, nasal sprays and inhalant medications 3/wk x 1 week; then 2x/wk x 1 week; then weekly with results reviewed at next Q.A. to determine if additional interventions are required as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions.</i></p> <p><i>Completion Date: 3/6/2013</i></p>	03/06/2013			

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	<p>he had not taken his Fluticasone Prop (Flonase) (anti-inflammatory) nasal spray. RN #24 was observed to give him his Flonase nasal spray medication. Resident #43 was observed to spray one nasal spray into one nostril followed within 5 seconds by a second nasal spray in this same nostril. He was then observed to complete this same process in his other nostril. No instructions were given by this nurse during this observation.</p> <p>Resident #43's clinical record was reviewed on 2/8/13 at 9:20 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, sleep apnea, and pneumonia.</p> <p>The physician order, dated 12/27/12, was Fluticasone Prop 50 micrograms (mcg) give 2 spray in each nostril once a day.</p> <p>The physician order, dated 12/27/12, was Spiriva Diskus 18 mcg handihaler inhale 1 capsule orally via handihaler device every using 2 separate inhalations and rinse mouth after use.</p> <p>The physician order, dated 12/27/12, was Pulmicort 180 mcg flexhaler inhale 1 inhalation orally 2 times a</p>						

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	<p>day.</p> <p>Due to the actions of the respiratory medications, the resident should have been instructed to take his Spiriva medication with 2 separate inhalations as ordered prior to the Pulmicort medication. Also, his mouth should have been rinsed out after the Spiriva and Pulmicort medications per manufacturer's instructions. With the Flonase spray a one minute waiting period should have been completed prior to the second nasal spray in each nostril.</p> <p>2. On 2/5/13 at 8:45 a.m., medication pass was observed. After preparing his medications, RN # 24 was observed to give Resident #21 his oral medications. Next, RN #24 gave the resident his Advair inhaler with no instructions to rinse his mouth after the inhaled medication.</p> <p>Resident #21's record was reviewed on 2/8/13 at 9:25 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, and pneumonia.</p> <p>The physician order, dated 12/20/12, was Advair 250-50 Diskus (anti-asthmatic) inhale 1 disk with</p>			

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	<p>device orally 2 times a day.</p> <p>On 2/5/13 at 2:20 p.m., during an interview RN #24 indicated she was not aware of any additional instructions needed when respiratory medications were given to a resident.</p> <p>On 2/7/13 at 5:10 p.m., during an interview the Director of Nursing indicated there was a waiting period between respiratory medications.</p> <p>On 2/8/13 at 10:50 a.m., during an interview LPN #26, who was working on Resident #21's hall, indicated Resident #21 would rinse his mouth after his inhaler when instructed.</p> <p>3. The "Policy and Procedure for Nasal Spray Administration/Inhalation" was provided by the Administrator on 2/8/13 at 9:10 a.m. This current policy indicated the following:</p> <p>"POLICY: Medications will be administered as ordered by the physician via nasal inhalation/spray route by qualified personnel.</p> <p>PROCEDURE: ...6. Hold the inhaler in an upright position for administration. 7. Instruct the resident to hold their</p>			

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	<p>breath while medication is administered and then breathe out through mouth.</p> <p>8. If more than one inhalation is ordered, repeat steps 6 and 7 above for each nostril for number of inhalation ordered....."</p> <p>On 2/8/13 at 10:15 a.m., the following was indicated:</p> <p>The "GERIATRIC MEDICATION HANDBOOK Eighth Edition" indicated the following:</p> <p>"...Inhaled Medications ...Spacing *Wait 1-2 minutes between "puffs" for multiple inhalations of the same medication... *Wait 1-2 minutes before administering the next medication ...Sequence 1. Beta Agonists...Long Acting...Serevent ...Promotes bronchodilation by relaxing bronchial smooth muscle ...Long-acting (12 hr duration) are used for prevention or maintenance only, NOT acute episodes... 2. Anticholinergic Agents... Long-acting Spiriva... 3. Corticosteroids.../Budesonide: Pulmocort... Fluticasone:...Advair...</p>			

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	<p>Rinse mouth after each use (do not swallow the rinse water) to help prevent oropharyngeal fungal infections...."</p> <p>"Nasal Spray Administration Procedure for Adults ...9. Hold the pump bottle ...15. Wipe any excess drainage...16. Repeat steps 9-15, if more than one spray is needed...."</p> <p>The "Nursing 2013 DRUG HANDBOOK" indicated the following:</p> <p>Pulmicort - "...Patient Teaching...rinse you mouth with water and then spit out the water after each dose to decrease the risk of developing oral candidiasis...."</p> <p>Flonase - "...Patient Teaching...Instruct patient to rinse his mouth and spit water out after inhalation...."</p> <p>Advair - "...Patient Teaching...Instruct patient to rinse mouth after inhalation to prevent oral candidiasis...."</p> <p>4. On 02/06/12 at 11:44 a.m., medication pass was observed. After preparing Resident #5's medication, RN #2 was observed to drop the medicated eye drop (Brimodine 0.2%</p>			

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	<p>- antiglaucoma) directly on each eye without lowering the lower eyelid to administer the medication.</p> <p>Record review of Policy and Procedure related to eye instillation of eye drops received on 2/8/13 at 9:10 a.m., from the Administrator, indicated that RN #2 did not follow procedure step number 4, failing to draw lower lid away from the eyeball, Step number 5, failing to instruct the resident to look up, and step number 6, not dropping the solution in the middle of the lower lid.</p> <p>The Geriatric Medication Handbook page 129, reviewed on 2/8/12 at 1:3., indicated to use gauze to pull down lower eyelid instructing patient to look up.</p> <p>5. On 02/04/13 from 11:11 a.m. to 11:18 a.m., medication pass was observed. LPN #26 was observed giving Resident #10 one dose of WelChol 625mg (antihyperlipidemic) by mouth. At this same time the information on the medication packet indicated this medication was to be given with food. The dining schedule received from Administrator upon arrival to facility on 02/04/13, indicated that lunch was served at 12 noon in the dining room.</p>				

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	<p>The Nursing 2013 Drug Handbook, reviewed on 02/08/13 at 9:45 a.m., indicated that WelChol was to be administered with a meal and plenty of fluids</p> <p>3.1-25(b)(9)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure a clean and sanitary kitchen related to hand washing, storage of dishes, dishwasher temperature, and expired food dates for 3 of 3 days of observation. (2/4/13, 2/6/13, and 2/7/13)</p> <p>B. Based on observation and interview, the facility failed to ensure handling of food and uniforms were maintained in a sanitary way for 1 of 2 dining room observations.</p> <p>This deficiency had the potential to affect 30 of 30 residents utilizing the kitchen services. (2/4/13 and 2/5/13 )</p> <p>Findings include:</p> <p>A.1. On 2/4/13 at 9:48 a.m., during the initial kitchen tour the following was indicated: Expired peanut butter, dated 10/2012, was being stored.</p>	F0371	<p>F371 It is the intent of this facility to provide sanitary food procurement, storage, preparation and service. <i>All residents of the facility have the potential to be affected. The corrective action taken for the same deficient practice is that inservicing of all dietary staff will be conducted on proper handwashing and procedures with return demonstrations to avoid possible contamination of food, etc. during preparation and serving of food as well as inservicing on proper dish storage procedures. A 100% audit of kitchen utensils/tools will be performed to check for any those that are in need of replacement. Inservicing will also include the procedure for dating of opened food items and the disposal of outdated food items. The dishwasher has been serviced and found to be operating as required and within regulation of chemical dishwasher requirements. The lights in the dishwashing storage area are equipped with a built-in shatter resistant shield/guard. The ice on the refrigerator walls has been</i></p>	03/06/2013			

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	<p>Ice was observed on the walls in the refrigerator with the thermometer reading at 32 degrees Fahrenheit (F). No covers were observed on the light fixtures in the dishwashing area and dry storage area.</p> <p>A.2. During kitchen observation on 2/5/13 at 8:40 a.m., open bags of food with no open dates were observed. At this same time during an interview, Dietary Aid #9 indicated the bags of food should have been dated.</p> <p>A.3. During kitchen observation on 2/6/13 at 10:00 a.m., the following was observed:</p> <p>Cook #6 was observed with 1 spatula with a torn edge and a pea-sized piece missing on this same edge. A second spatula was observed with a rough edge also.</p> <p>The trash can next to the preparation table was observed with dried food covering the lid. Next, Cook #6 was observed with glove hands as she was preparing food for lunch. During this observation she was observed to touch the top of the soiled trash can with her gloved hand and continued to prepare the pureed food.</p>		<p><i>removed and the refrigerator serviced. All staff will be inserviced on the requirement for hairnets in the kitchen, serving of food and feeding residents to avoid contamination, and on uniform cleanliness. Staff will be inserviced on the usage of alcohol based sanitizer and use of such and handwashing requirement/policy after every 5 th use or more frequently as warranted. The measures and systemic changes put into place to ensure that the deficient practice does not recur is that Q.A. monitoring tools have been developed and implemented to monitor for proper handwashing technique, proper alcohol based sanitizer use, proper dish storage, dishwasher functionality, utensil/tool adequacy, uniform cleanliness, and food dating/disposal as required. These tools will be utilized 5x/wk x 1 week; then 3x/wk x 1 week ; then 2x/wk x 1 week; then weekly The tool will be monitored by the Administrator or designee with results reviewed at next Q.A. to determine if additional interventions are required as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions. Completion Date: 3/6/2013 . Completion Date: 3/6/2013</i></p>				

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	<p>After having completed preparing the first serving of the pureed food, Cook #6 proceeded to rinse and then, place the pureed equipment in the dishwasher. During this observation of the dishwasher, Cook #6 indicated the dishwasher method was chemical with the minimum wash water was to be at 120 degrees F as indicated on the dishwashing machine. No temperature reading from the designated dishwasher temperature gauge was observed. The second dishwashing temperature read 115 degrees F. When a thermometer was placed inside the wash to check for accuracy, the dishwashing wash temperature was 117 degrees F.</p> <p>Next, Cook #6 continued to prepare the pureed food servings with no handwashing observed between tasks.</p> <p>As Cook #6 obtained a piece of shrink plastic wrap, the plastic wrap was observed against her uniform as she cut the piece from the roll, which was used to cover the pureed salad servings.</p> <p>Cooking pans under the counter were indicated as ready for use by Cook #6 and were observed wet.</p>				

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	<p>CNA #25 was observed to enter the kitchen without a hair cover.</p> <p>The "WAREWASH/KITCHEN SERVICE REPORT" report, dated 2/6/13, was provided by the Administrator on 2/6/13 at 9:10 a.m. This report indicated the following:</p> <p>"...Services Performed / Recommendations / Training Provided ...Serviced Machine Temp Gauge Broke Had to Order...."</p> <p>The "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS Title 410 IAC 7-24" indicated the following:</p> <p>"...shall wear hair restraints, such as hats, hair coverings or net...that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles...."</p> <p>B.1. On 2/4/13 at 12:00 p.m., during lunch observation CNA #3 was observed applying butter to resident #31's bread with bare hands. CNA #7</p>						

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	<p>was observed to butter a biscuit with bare hands for resident #12. Also, CNA #3 was observed coughing in a paper towel and wiping her nose. No handwashing/handgel was observed as CNA #3 continued to feed unidentified residents.</p> <p>B.2. On 2/7/13 at 12:01 p.m., during a meal observation, CNA #4, CNA #6, CNA #3, and CNA #5 were observed serving residents' meal trays 5 consecutive times using hand sanitizer between these servings with no handwashing observed after the 5th meal tray. Also, CNA #5 and CNA #6 were also observed passing trays in the dining room with the bottom of their pants dragging on the floor. These dragging areas of the pants were observed with a brown ring around the bottom of these pants.</p> <p>The "Policy and Procedure for use of Hand Sanitizing Gel/Foam/Alcohol Based Sanitizers" was provided by the Administrator 2/8/13 at 9:10 a.m. This current policy indicated the use of sanitizing gels/foams/alcohol-based sanitizer in place of hand washing was allowed per the following guidelines: "...3. Product may be used up to 5 times and then hands must be</p>			

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	<p>washed per hand washing policy and procedure....."</p> <p>The policy for hand washing in the dietary department was provided by the Administrator on 2/8/13 at 9:10 a.m. This current policy indicated the following:</p> <p>"2. Apply soap to wet hands. 3. Rub hands together vigorously for 20 seconds including between fingers and under nails covering all surfaces of hand. 4. Rinse hands thoroughly with warm running water. 5. Dry thoroughly with disposable paper towel. 6. Turn off faucet at hand washing sink with disposable paper towel and dispose of used paper towel in trash container."</p> <p>The policy titled "Storage of Clean Dishes" was provided by Dietary #9 on 2/8/13 at 11:06 a.m. This current policy indicated the following: "1. After dishes are washed, allow to air dry. ...3. Clean dry dishes should be stored in the appropriate designated area."</p> <p>3.1-21(i)(2)</p>				

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F0441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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, record review, the facility failed to</p>	F0441	F441 It is the intent of this facility to maintain an infection control	03/06/2013

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	<p>ensure infection practices were followed related to handwashing/glove use during medication pass for 2 of 19 residents observed (Resident #21 and #15) for 1 of 4 nursing staff observed (RN #24) during medication pass and for 2 of 6 residents observed during personal care. (Resident #1 and #29)</p> <p>Findings include:</p> <p>1. On 2/5/13 at 8:32 a.m., during medication pass observation Resident #21 was observed holding his lower dentures. He was observed to show this set of dentures to RN #24 explaining he had dropped them chipping off a piece of his denture. RN #24 was observed to obtain the resident's denture cup from his drawer in his room. After the resident put them in the denture cup, RN #24 left the room and made a note concerning the dentures on her note pad. No handwashing/handgel use was observed. Next she went to the linen closet where she obtained a clean washcloth from the shelf. After taking Resident #15 to her room, RN #24 was observed to don a pair of gloves, wet the washcloth in the resident's bathroom, and wiped the dried blood off of her hand and then,</p>		<p>program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of diseases and infection. All residents of the facility have potential to be affected. <i>The corrective action taken to ensure that the deficient practice does not recur is that all staff will be inserviced on hand washing and the use of hand sanitizer between all residents, prior to and after medication passes, and after any contact with a resident. The measures or systemic changes that have been put into place to ensure that that deficient practice does not recur is that a Q.A. tool has been developed and implemented to monitor staff handwashing with return demonstration of staff member followed up with random return demonstrations of 3 staff members 5x/wk x 1 week; then 3 staff 3x/wk; then 2 staff 2x/wk; then two staff weekly with results reviewed at next Q.A. to determine the need for additional interventions required as evidenced by accuracy rate of 5% or less. Greater than 5% will warrant further interventions.</i></p> <p>Completion Date: 3/6/2013</p>				

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	<p>dried the resident's hand with a paper towel. After removing her gloves, no handwashing/handgel use was observed. Then, RN #24 was observed to take the soiled washcloth to the soiled utility room linen barrel, obtained a bottle of handgel from the nurse's station drawer and returned to the medications cart before using this bottle of handgel as she was observed to prepare Resident #21's medications.</p> <p>The "MEDICATION: ORAL AND SUBLINGUAL ADMINISTRATION" was provided by the Administrator on 2/8/13 at 9:10 a.m. This current policy indicated the following:</p> <p>...PROCEDURE: ...3. Wash hands with soap and water before and after each resident . Hand wash Foam/gels/alcohols may be used between residents...."</p> <p>2. On 2/7/13 at 11:23 a.m., Resident #29's personal care was observed. CNA #6 and CNA #3 was observed to handwash for 13 seconds and 8 seconds respectfully, after the resident's personal care was completed.</p> <p>On 2/6/13 at 2:51 p.m., personal care for Resident #1 was observed. CNA #1 was</p>			

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	<p>observed to handwash for 7 seconds, and then, she was observed to turn the water off with her wet hands before drying her hands during this personal care observation. CNA #2 was also observed to handwash for 5 seconds during this observation.</p> <p>On 2/6/13 at 2:55 p.m. during an interview, CNA #1 indicated one should handwash for 20 seconds, and CNA #2 indicated one should handwash for 30 seconds.</p> <p>The handwashing policy and procedure was provided on 2/8/13 at 9:10 a.m. by the Administrator. This current policy indicated hands should be washed for 10 seconds (5. Lather all areas of hands and wrists, rubbing vigorously. Wash between your fingers, the backs of your hands, your palms, and around your fingernails. Continue this scrubbing action for at least ten seconds. Cleans you nails by rubbing under them in the palm of your other hand.)</p> <p>3.1-18(l)</p>			

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