

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/21/2014
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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00144974.</p> <p>Complaint : Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F312 and F353.</p> <p>Survey dates: March 10, 11, 12, 13, 14, 16, 17, 18 and 21, 2014.</p> <p>Facility number: 000195 Provider number: 155298 AIM number: 100267690</p> <p>Survey team: Gloria Bond, R.N.-- Team Coordinator Michelle Hosteter, R.N. (3/10, 3/11, 3/12, 3/13, 3/14, 3/17, 3/18, 21, 2014) Sandra Nolder, R.N. (3/10, 3/11, 3/12, 3/13, 3/14, 3/17, 3/18, 21, 2014)</p> <p>Census bed type: SNF/NF--69 Total--69</p> <p>Census payor type: Medicare--11 Medicaid--45 Other--13 Total--69</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on March 31, 2014.</p>	F000000	<p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></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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F000157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to notify the physician about a change in condition and critical lab values for a resident which resulted in hospitalization for this resident for</p>	F000157	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B was admitted to the</p>	04/20/2014

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	<p>an infection that met the criteria for Sepsis. In addition, the facility failed to notify the physician about a change in condition of a skin burn on a resident resulting in an infection. (Residents B and #6).</p> <p>Findings include:</p> <p>1. On 3/11/2014 at 10:35 A.M., Resident B was observed in her room and was able to give her name and comment on the breakfast she was eating.</p> <p>On 3/12/2014 at 9:30 A.M., Resident B was observed in her room able to finish an interview and share her likes and dislikes.</p> <p>On 3/13/2014 at 10:50 A.M., the resident was observed in her room in bed with eyes closed.</p> <p>On 3/14/2014 at 6:35 P.M., the resident was observed in her room up in her wheelchair trying to eat, but short of breath and not speaking.</p> <p>On 3/16/2014 at 5:50 P.M., the resident was observed in her room sitting up in her wheel chair, short of breath and trying to reach and push her call light.</p> <p>On 3/17/2014 at 11:00 A.M., the resident was observed in her room in bed.</p> <p>On 3/18/2014 at 9:55 A.M., the resident was not in her room. In an interview at this time, LPN #1 indicated the resident's family requested the resident be sent out to an acute care hospital on the evening of 3/17/2014.</p> <p>Resident B's record was reviewed on</p>		<p>hospital and returned in stable condition while survey was still in progress. Per hospital admitting and discharge paperwork, diagnosis of sepsis was not found.</p> <p>The physician was notified of the skin condition for Resident 6 once the area was identified as a burn. Treatment orders were received at that time. The Nurse Practitioner provided new orders once she identified the condition of the skin had worsened.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents having a change in condition have the potential to be affected by the alleged deficient practice. A complete audit was immediately initiated to identify any residents with unaddressed critical labs or changes in condition. No new concerns were identified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Licensed nursing staff were</p>	

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	<p>3/18/2014 at 10:00 A.M. Diagnoses included, but were not limited to, osteoarthritis shoulder region, anemia in chronic kidney disease, hypothyroidism, hypertension and diabetes. A "Change of Condition" SBAR [Situation, Background, Assessment, Response], dated 3/16/2014 at 10:00 P.M. indicated Resident B was verbally responsive though not able to effectively communicate as usual. "Unable to form complete words... MD response: New orders: CBC [Complete Blood Count]; BMP [Basic Metabolic Panel]; UA C&S [Urinalysis Culture and Sensitivity]."</p> <p>Blood work was drawn on 3/17/2014 at 6:27 A.M. Results of lab work was faxed to the facility at 12:45 P.M., because the lab was "unable to reach nurse by phone." The lab indicated the resident's blood glucose level was 33 mg/dL with the reference range of 64 - 112, indicating a critically low level. The WBC (white blood cell count) was 15.5 x 10³/uL with the reference range being 4.2-10.0, indicating a high level.</p> <p>The record indicated the lab results were not called to the Physician. The Physician was not notified.</p> <p>There was no nursing documentation for the evening of 3/17/14 until a late entry made on 3/18/14 at 12:20 P.M., for 3/17/14 at 6 P.M., indicated the resident's family requested she be sent out as she was "not herself." Vital signs taken at that time indicated the following: "BP[blood pressure] 130/70, P[pulse] 95, R[respirations] 19, Sat [oxygen saturation] 87 percent, T [temperature] 100.9 Fahrenheit."</p> <p>Resident B's record indicated the physician had been notified of her critical lab values at 3:30 p.m. on 3/17/14. In an interview on 3/18/14 at 3:00 P.M., the NP(Nurse Practitioner) indicated she was not called regarding the lab values or the residents</p>		<p>re-inserviced regarding timely and appropriate physician notification.</p> <p>Nurse management has implemented a lab tracking system to ensure that labs are obtained as ordered and results are addressed as indicated.</p> <p>Nurse management or their designee will review all completed SBARs for change of condition to ensure timely and appropriate physician notification.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>These reviews will be completed at least three times a week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>change in condition until after 6:00 P.M., when the resident's family requested she be sent out to the acute care hospital.</p> <p>The (name of hospital) acute care hospital record for Resident B was reviewed on 3/18/14 at 2:30 P.M. The hospital's "AIMS history and physical" record dated 3/17/14 indicated the resident was found to have altered mental status, her blood sugar was 51 mg/dL, her white blood count was significantly elevated, and a urinalysis was found to show the resident had a marked number of bacteria in her urine and met the criteria for Sepsis (a potentially life threatening complication of an infection).</p> <p>2. During an interview on 3/14/14 at 12:53 P.M., LPN #5 indicated that Resident #6 was getting a dressing change to his chest because he received a burn last week from hot coffee. She indicated the resident did not eat or drink anything by mouth.</p> <p>During a dressing change observation with LPN #16, on 3/14/14 at 5:08 P.M., the resident was observed to have a burned area from his right collar bone area down his chest and abdomen into the right suprabupic area. The right collar bone area was beginning to scab. The skin was peeled off the entire area. The mid abdomen area and under the G-tube had 6 areas with yellow slough tissue (dead tissue covering the wound bed). The right outer side of the mid abdomen area had a pea size area that was actively bleeding a scant (small) amount of blood when the dressing was removed. The old dressing had a small amount of serous (yellow colored) drainage on it.</p>			

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	<p>Resident #6's record was reviewed on 3/14/14 at 4:46 P.M.</p> <p>A nurses note, dated 3/7/14, at 3:30 P.M., indicated the resident sustained a burn to his chest while in activities. He reached for another resident's hot coffee and spilled it on him. During the assessment of the resident 7 fluid filled blisters was found on his chest from his right shoulder to his suprapubic area. The Physician's office was notified.</p> <p>A nurses note, dated 3/7/14, at 9:30 P.M., indicated a new order was given for Silvadene cream to the burned area and then to cover it.</p> <p>A nurses note, dated 3/8/14, at 12:00 P.M., indicated during the assessment of the burned area, the area was noted to be red and there were blisters at the abdomen that had broken and some of the areas were draining serous fluid. The treatment was completed as ordered. The note indicated there were no signs or symptoms of infection.</p> <p>A nurses note, dated 3/8/14, at 10:00 P.M., indicated when the old dressing was removed, there was yellow drainage noted to two areas on the lower abdomen. The dressing change was completed as ordered.</p> <p>There was no documentation of measurements of the blisters or redness that were noted in the record on 3/7/14 at 3:30 P.M.</p> <p>There was no documentation of assessments of wound care for a burn wound from 3/8/14 at 10:00 P.M., until 3/11/14 when the Nurse Practitioner came in a assessed the wounds.</p>			

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	<p>A nurses note, dated for 3/13/14, at 9:00 A.M., indicated the resident's burn measured 48.0 x 16.0 x <0.1 cm. The wound spanned from his right collar bone on the right side of the sternum down to the right superapubic area. The wound bed was reddened. The treatment was completed as ordered.</p> <p>There was no further documentation provided regarding the assessment of wound care or measurements of the blisters from 3/7/14 at the end of the exit conference on 3/21/14 at 3:15 P.M.</p> <p>A Physician progress notes dated 3/11/14 indicated the resident had coffee spilled on him over the weekend. The note indicated the initial call into the Physician office stated, "Patient had reddened area near right scapula size of quarter." The note indicated the resident now had second degree burns from the left shoulder through the chest and abdomen area into the suprapubic area and he complained of severe pain and discomfort.</p> <p>The Physician's progress notes dated 3/12/14 indicated the resident had a diagnosis of second degree burn of the skin and was ordered an antibiotic (Keflex) for condition of the burn site.</p> <p>During an interview on 3/14/14 at 4:10 P.M., the Director of Nursing indicated the resident was burned on 3/7/14 by reaching for someone else's coffee in an activity and the skin was red on 3/7/14 and 3/8/14. She indicated the skin on his chest peeled off on 3/13/14, so the wound had to be dressed with Silvasorb ointment.</p> <p>During an interview on 3/14/14 at 6:30 P.M.,</p>			

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	<p>Nurse Consultant #3 indicated she had seen the nurses notes, which indicated the resident had 7 fluid filled blisters on 3/7/14 after he was burned by the coffee. She indicated the Director of Nursing (DoN) was not given this information when she received the call from the nurse on 3/7/14. Nurse Consultant #3 indicated RN #17 assessed the wound on 3/8/14 and she did not see any blisters on the resident's chest that day and all she noted was redness. Nurse Consultant #3 indicated the nurse did not notify the DoN of the severity of the wound on 3/7/14. She indicated the nurse who assessed the resident after the burn on 3/7/14 did not complete the SBAR (Situation, Background, Assessment and Request) or measure the wound as per the policy.</p> <p>During an interview on 3/17/14 at 11:26 A.M., the Nurse Practionioner indicated she was notified on 3/7/14 the resident was burned by coffee and had reddened areas. She indicated she did not know until she came in to assess the resident on 3/11/14 that he had full blown blistering and she seen it with her own eyes. She indicated when she took the dressing off on 3/11/14 the wound edges were dry from the Silvadene cream and when she pulled the gauze dressings off that could have caused the skin to peel off.</p> <p>A current policy titled "Covenant Care Operating Standard Managing Change of Condition" dated October 2011, was provided by Nurse Consultant #4 on 3/18/14 at 2:00 P.M. The policy indicated, "...Practice Standards:... If the change in condition does not appear life-threatening, the following steps may be followed: 1. Select and complete each section of the appropriate COC SBAR or Report of Incident SBAR...2.</p>			

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F000225 SS=D	<p>Notify physician and responsible party of assessment findings...4. Document assessment findings and communications. 5. Report change of condition to DON, ED, and other members of the IDT per facility practice...."</p> <p>3.1-5(a)(2) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his</p>			

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	<p>designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed to immediately report allegations of physical abuse, to the Executive Director, for 1 of 4 allegations reviewed and failed to report an unusual occurrence to the State Agency within 24 hours for 1 of 1 residents reviewed for unusual occurrences . (Residents #6 and #93)</p> <p>Findings include:</p> <p>1. During an interview on 3/11/14 at 1:20 P.M., Resident #93 was overheard discussing with the CNA #10 and #11 that he had not wanted to take a medication and a nurse "shoved" the medication into his mouth and made him take it anyway. The CNA's asked him why he did not want the medication and who the nurse was that "shoved" the medication into his mouth. The resident stated, "You two think I am crazy don't you?"</p> <p>During an interview on 3/11/14 at 3:17 P.M., Resident #93 indicated he asked LPN #9 for a blanket on night shift on 3/10/14 before 6:00 A.M. He indicated LPN #9 told him to, "Go to sleep. Everyone else is asleep." "If you don't go to sleep I am coming back with the medicine and you are taking it." He indicated she came back with medication. When he asked what the medication was for, she told him, "To quiet you down." He</p>	F000225	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Social Service Director and Executive Director immediately initiated an investigation upon notification of the alleged abuse by the surveyor. The investigation did not support the Resident 93's allegation that the resident was forced to receive his prescribed pain medication. This resident routinely voices concerns that are not possible to substantiate and do not match facts discovered during investigation. Staff were immediately re-inserviced regarding the expectation to immediately report allegations of physical abuse to the Executive Director. The Executive Director promptly notified the Indiana State Department of Health of the allegation. The physician was notified of the skin condition for Resident 6 once the area was identified as a burn. Treatment orders were received at that time. The Nurse Practitioner provided new orders once she identified the condition of the skin had worsened. The burn was reported to the Indiana State</p>	04/20/2014

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	<p>indicated he told LPN #9 he did not want the medication, but she "shoved" the medication down his throat. He indicated the nurse placed the spoon in the right corner of his mouth and "shoved" the spoon to the front of this mouth where his teeth were and she pushed down on the plastic spoon in his mouth forcefully to get the medication off the spoon. She had not placed her hands on him anywhere while she "shoved" the medication down his throat. He indicated he had no choice, but to swallow the medication, but he did not want the medication. He indicated he had asked for juice after the medication and she gave him a little amount of juice after the medication.</p> <p>Resident #93 indicated he had told two "workers" about the incident with the medication. The "workers" were CNA #10 and CNA #11 when they were placing him into the bed after lunch. He indicated he asked the CNA's if the nurse could make him take medication that he did not want to take. He was told by the CNA's that the nurse could not make him take medication he did not want. He indicated he did not feel like he should have to fight the nurse and spit the medication out, so he swallowed it. He indicated if she would force medications onto him, he was concerned she would do that to others who could not speak out for themselves. He indicated he did not understand why she would make him take medication he did not want. He indicated, "I can't believe nurses in your profession treat human beings like this."</p> <p>The resident's record was reviewed on 3/14/14 at 3:41 P.M. The Quarterly Minimum Data Set assessment dated 1/7/14 indicated his Brief Interview for Mental Status</p>		<p>Department of Health. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Any resident alleging abuse has the potential to be affected by the alleged deficient practice. A random audit was initiated to identify any residents with unaddressed allegations. No new concerns were identified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? Staff were immediately re-inserviced regarding the expectation to immediately report allegations of physical abuse to the Executive Director. Random audits of five staff will be completed twice weekly to test staff competency in proper reporting procedures. The Executive Director and Nurse managers were re-educated regarding the reportable guidelines. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? These random audits will be completed twice weekly for at least four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>was a 13 (13-15 indicated cognitively intact).</p> <p>During an interview on 3/11/14 at 3:40 P.M., the Executive Director (ED) indicated he had not been notified of Resident #93's alleged physical abuse, but he would check with the Director of Nursing (DoN) or the Assistant Director of Nursing (ADoN) because one of them may have been notified and not have told him as of this time.</p> <p>During an interview on 3/11/14 at 4:30 P.M., CNA #12 indicated the resident had told her this afternoon that a nurse made him take medicine he did not want to take. She indicated she had reported the abuse allegation to RN #13 and she had told her that he was on medications for those behaviors.</p> <p>During an interview on 3/11/14 at 4:39 P.M., RN #14 indicated CNA #12 had not reported anything to her regarding this resident this afternoon since she had started her shift.</p> <p>During an interview on 3/11/14 at 5:30 P.M., the ED indicated he and the Social Service Director had interviewed the resident earlier today. The details the resident told them about the event that occurred regarding the medication was inconsistent with the information he was given earlier. He indicated he had started the investigation and was going to send a report to the Indiana State Department of Health (ISDH). He indicated the DoN would interview LPN #9.</p> <p>During an interview on 3/14/14 at 5:42 P.M., the Assistant Director of Nursing indicated she expected the nursing staff to report allegations of abuse immediately to the ED.</p>			

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	<p>During an interview on 3/17/14 at 9:35 A.M., the Dietary Manager indicated she expected the dietary staff to report allegations of abuse immediately to the ED.</p> <p>During an interview on 3/17/14 at 5:50 P.M., the DoN indicated she expected the staff to report allegations of abuse as soon as possible to the ED.</p> <p>During an interview on 3/21/14 at 10:00 A.M., the ED indicated he was not immediately notified about the resident's abuse allegations as the policy and procedure required.</p> <p>2. The resident's record was reviewed on 3/14/14 at 3:41 P.M. The Quarterly Minimum Data Set assessment dated 1/7/14 indicated his Brief Interview for Mental Status was a 13 (13-15 indicated cognitively intact).</p> <p>The record indicated during an activity on 3/7/14 at 11:00 A.M., Resident #6 reached for another resident's coffee during an activity and spilled it on his chest and abdomen.</p> <p>The Physician's progress notes dated 3/12/14 indicated the resident had a diagnosis of second degree burn of the skin.</p> <p>During an interview on 3/14/14 at 6:30 P.M., Nurse Consultant #3 indicated the DoN did not file the report with the Indiana State Department of Health (ISDH) in a timely manner.</p> <p>During an interview on 3/21/14 at 10:00 A.M., the Executive Administrator (ED) indicated the reportable for the second degree burn should have been sent to the ISDH on 3/12/14 instead of 3/13/14.</p>			

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F000226 SS=D	<p>A document titled "Attachment A Incident Management Operating Standards Federal and State Reporting Requirements" provided by the DoN on 3/14/14 at 6:00 P.M., indicated "...Procedure: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division, CFR 483.13(c)(2) states, that [the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator or the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency)...Significant Injuries: Burns greater than first degree...."</p> <p>3.1-28(c) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 observation, interview and record review, the facility failed to implement their Abuse Prevention policy/procedures, related to immediately notifying the Executive Director or designee of an allegation of physical abuse in 1 of 4 residents reviewed for allegations of abuse. (Resident # 93)</p> <p>Findings include:</p>	F000226	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The Social Service Director and Executive Director immediately initiated an investigation upon notification of the alleged abuse</p>				

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	<p>During an interview on 3/11/14 at 1:20 P.M., Resident #93 was overheard discussing with the CNA #10 and #11 that he had not wanted to take a medication and a nurse "shoved" the medication into his mouth and made him take it anyway. The CNA's asked him why he did not want the medication and who the nurse was that "shoved" the medication into his mouth. The resident stated, "You two think I am crazy don't you?"</p> <p>During an interview on 3/11/14 at 3:17 P.M., Resident #93 indicated he asked LPN #9 for a blanket on night shift on 3/10/14 before 6:00 A.M. on the night shift on Monday 3/10/14 before 6:00 A.M. He indicated LPN #9 told him to, "Go to sleep. Everyone else is asleep." "If you don't go to sleep I am coming back with the medicine and you are taking it." He indicated she came back with medication. When he asked what the medication was for, she told him, "To quiet you down." He indicated he told LPN #9 he did not want the medication, but she "shoved" the medication down his throat. He indicated the nurse placed the spoon in the right corner of his mouth and "shoved" the spoon to the front of this mouth where his teeth were and she pushed down on the plastic spoon in his mouth forcefully to get the medication off the spoon. She had not placed her hands on him anywhere while she "shoved" the medication down his throat. He indicated he had no choice, but to swallow the medication, but he did not want the medication. He indicated he had asked for juice after the medication and she gave him a little amount of juice after the medication.</p> <p>Resident #93 indicated he had told two "workers" about the incident with the medication. The "workers" were CNA #10</p>		<p>by the surveyor. The investigation did not support the resident's allegation that the resident was forced to receive his prescribed pain medication. This resident routinely voices concerns that are not possible to substantiate and do not match facts discovered during investigation.</p> <p>Staff were immediately re-inserviced regarding the expectation to immediately report allegations of physical abuse to the Executive Director.</p> <p>The Executive Director promptly notified the Indiana State Department of Health of the allegation.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>Any resident alleging abuse has the potential to be affected by the alleged deficient practice. A random audit was initiated to identify any</p>	

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	<p>and CNA #11 when they were placing him into the bed after lunch. He indicated he asked the CNA's if the nurse could make him take medication that he did not want to take. He was told by the CNA's that the nurse could not make him take medication he did not want. He indicated he did not feel like he should have to fight the nurse and spit the medication out, so he swallowed it. He indicated if she would force medications onto him, he was concerned she would do that to others who could not speak out for themselves. He indicated he did not understand why she would make him take medication he did not want. He indicated, "I can't believe nurses in your profession treat human beings like this."</p> <p>The resident's record was reviewed on 3/14/14 at 3:41 P.M. The Quarterly Minimum Data Set assessment dated 1/7/14 indicated his Brief Interview for Mental Status was a 13 (13-15 indicated cognitively intact).</p> <p>During an interview on 3/11/14 at 3:40 P.M., the Executive Director (ED) indicated he had not been notified of Resident #93's alleged physical abuse, but he would check with the Director of Nursing (DoN) or the Assistant of Nursing (ADoN) because one of them may have been notified and not have told him as of this time.</p> <p>During an interview on 3/11/14 at 4:30 P.M., CNA #12 indicated the resident had told her this afternoon that a nurse made him take medicine he did not want to take. She indicated she had reported the abuse allegation to RN #14 and she had told her that he was on medications for those behaviors.</p>		<p>residents with unaddressed allegations. No new concerns were identified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Staff were immediately re-inserviced regarding the expectation to immediately report allegations of physical abuse to the Executive Director. Random audits of five staff will be completed twice weekly to test staff competency in proper reporting procedures.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>These random audits will be completed for at least four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>During an interview on 3/11/14 at 4:39 P.M., RN #14 indicated CNA #12 had not reported anything to her regarding this resident this afternoon since she had started her shift.</p> <p>During an interview on 3/14/14 at 5:42 P.M., the Assistant Director of Nursing indicated she expected the nursing staff to report allegations of abuse immediately to the ED.</p> <p>During an interview on 3/17/14 at 9:35 A.M., the Dietary Manager indicated she expected the dietary staff to report allegations of abuse immediately to the ED.</p> <p>During an interview on 3/17/14 at 5:50 P.M., the DoN indicated she expected the staff to report allegations of abuse as soon as possible to the ED.</p> <p>During an interview on 3/21/14 at 10:00 A.M., the ED indicated he was not immediately notified about the resident's abuse allegations as the policy and procedure required.</p> <p>A current policy dated 09/2011 titled, "Abuse Prevention, Intervention, Investigation & Crime Reporting Policy" was provided by the DoN on 3/13/14 at 3:47 P.M. The policy indicated, "...It is the responsibility of employees to immediately report to the facility administrator...any incident of suspected or alleged neglect or resident abuse from other residents, staff, family, or visitors...6. Reporting...Additionally, the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's responsibility</p>			

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F000241 SS=D	<p>to protect residents and promptly investigate occurrences may be met...."</p> <p>3.1-28(a) 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 and interview the facility failed to provide care in a dignified manner for 1 out of 4 resident's reviewed for dignity. (Residents C).</p> <p>Findings include:</p> <p>1. In an interview on 3/12/14 at 1:40 P.M., Resident C indicated staff do not treat him with respect and dignity. He indicated he did not get the mouth care he needs, his urinal did not get emptied regularly, and he has had to wait soiled after a bowel movement for a long time and was not been able to receive therapy as a result.</p> <p>In an interview on 3/13/14 at 11:55 A.M., the resident indicated his trach tube dressing was changed last evening and it was "nasty." He reminded the nurse on days today and he said, "she doesn't care but it's my life."</p> <p>On 3/17/14 at 3:30 P.M., the resident's oxygen tubing was on the floor on the left side of his bed. The sterile water bag attached to his oxygen tubing on one side and tubing to his tracheostomy on the other was sitting on the floor and cords were laying on top of it.</p>	F000241	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident C has had a thorough review of his care plan and revisions have been made to reflect his personal preferences and attitude towards staff. Ample documentation was provided to the surveyor indicating the abusive behavior of this resident toward staff and their frequent attempts to meet his needs.</p> <p>Resident C's room environment was inspected and improved as he would allow.</p> <p>How will other residents having</p>	

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	<p>On 3/21/2014 at 10:15 A.M., Resident C was observed in his room with a half full urinal on his bedside table. A folded zippered pillow case with several brown like substances or stains was under his right thigh and knee area. Oxygen tubing was on the floor of the left side of his bed and multiple cords were near it. The sterile water bag attached to his oxygen tubing on one side and tubing to his tracheostomy on the other was sitting on the floor. His tracheostomy dressing was damp and yellowish tinge mucus was coming through to the right side. There was redness on the exposed skin near the dressing to his tracheostomy in the middle. The resident's right leg was uncovered with no foot coverings to his foot. He was wearing a hospital type gown. On the left side of his bed on the floor was trash scattered near an almost full trash can.</p> <p>The resident indicated at this time that his urinal did not get emptied regularly. He indicated his dressing around his tracheostomy was uncomfortable when it was wet.</p> <p>This Federal tag relates to Complaint IN00144974.</p> <p>3.1-3(t)</p>		<p>the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. A complete audit was performed with interviewable residents to identify any other concerns regarding dignity and respect.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Staff were re-inserviced regarding resident rights and dignity. Management team members were assigned to perform resident rounds at least twice weekly and pursue corrective actions as identified.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p>		

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to meet the individual activity program needs for 2 of 3 residents reviewed for Activities. (Residents # 3 and # 8)</p> <p>Findings include:</p> <p>1. The record for Resident #3 was reviewed on 3/14/14 at 2:00 P.M. Diagnoses included, but were not limited to, heart failure, high blood pressure, stroke, and dementia.</p> <p>On 3/10/2014 at 3:19 P.M., the resident was observed in bed and the television set was turned on.</p> <p>On 3/13/14 from 10:25 A.M., through 11:55 A.M., while group activities of music and bible quiz were being conducted by the facility Activity Department in another part of the building, the resident was observed to be in bed.</p>	F000248	<p>These resident rounds will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 3 has a documented diagnosis for dementia and often does not recall participation or invitation to activities. She has had her activities care plan re-evaluated by a hired outside consultant. Review of the resident's activities, as reflected within the 2567, indicated that the resident does regularly participate in a wide variety of activities. Her preference to do activities independently in her room is now reflected on her care plan. Resident 8 has a documented diagnosis for being aphasic and in a persistent vegetative state. She has had her activities care plan re-evaluated by a hired</p>	

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	<p>On 3/14/14 at 10:40 A.M., the resident was observed to be in bed. A group activity of "Exercise" was being conducted by the Activity Department at that time in another area of the building.</p> <p>On 3/17/14 at 9:04 A.M., the resident was laying in bed, watching television. There was music playing in the lounge area on the 3rd floor at 9:09 A.M.</p> <p>In an interview on 3/17/14 at 4:15 P.M., the resident indicated she had not participated in the St. Patrick's Day party because she had not been invited.</p> <p>The initial activity assessment, dated 6/5/13, indicated the resident felt it was very important to have music, books, newspapers or magazines to look at, to be around pets, do things outside. She listed her favorite activities as sewing, taking care of kids and television.</p> <p>The most recent quarterly activity assessment, dated 2/6/14, indicated the following:</p> <p>"...How does resident choose to spend his/her time? Music, socializing with staff and peers, visits, socials, parties, games, church services, special entertainment, happy hour, manicures, cooking club, exercise, etc.</p> <p>Describe interventions activities provides: Activities staff will invite, encourage, assist, and escort/as needed to therapeutic recreation activities based on personal leisure preferences daily..Preferred activity setting: Group, Independent and room</p>		<p>outside consultant. Review of the resident's activities indicates that the resident passively participates in a wide variety of activities on a regular basis, and her capacity to participate is now reflected on her care plan. The facility's licensed recreational therapist completed a new Quality of Life Initial Assessment form on both residents to identify current interests and preferences. Activities personnel will continue to involve these residents in activities to the extent of their respective capacities, including 1:1 programming, independent activities and group activities when applicable. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. A complete audit was performed to identify any other residents who could allegedly be at risk for lacking to have their individual activity program needs met. With the assistance of a hired outside consultant, a Resident Activity Level Assessment was completed to identify facility activity needs and to re-evaluate the activity program. What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? The</p>	

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	<p>checked...."</p> <p>The activity Care Plan, dated 2/6/14, indicated the resident would participate in 2-4 activities a week and these "could include: Manicures, Bible Study, Sweet Shop, exercise, games, live music, as well as a variety of music such as Jazz, Gospel, and Occasional Holiday Music." Interests relating to pet visits, outside activities or sewing, which were listed as very important in the initial activity assessment, were not included.</p> <p>The March activity calendar for the facility indicated there were manicures offered on March 6th and 13th. The Sweet Shop activity was on the 4th and 11th.</p> <p>The individual Activity Participation Log sheet listed a "response" key, to identify the level of participation by the resident: "R" for Refused, "I" for Independent, "A" for Active, and "L" for Listened.</p> <p>The Activity Participation Log for Resident #3 for March, 2014, indicated the following: March 15 to 17: the form was blank without any documentation of activities. Boxes for the dates of the "Sweet Shop" and "Manicures" were blank. The boxes for "Arts and Crafts," "Knitting/Crocheting," and "Room Crafts" were blank.</p> <p>The January and February, 2014 Activity Participation Log only had marks for "Movies," "Music," "Snack," "Socializing," and "Television." There were no refusals noted on any of the activity logs to indicate the resident had been offered manicures, sweet shop, or other activities, and had refused them.</p>		<p>licensed recreational therapist has made adjustments as indicated to increase participation in programs for lower functioning residents. The facility's licensed recreational therapist completed an inservice for activity staff regarding sensory stimulation programming and activities for lower functioning residents. The Activities personnel will track 1:1 programming, group programming and independent activity participation on separate forms for each resident. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The activity participation logs will be reviewed on a weekly basis by a consultant for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>In an interview on 3/18/14 at 10:40 A.M., the Activity Director indicated the resident was invited to all activities. If the resident was offered a specific activity but refused it, the staff should have indicated that on the activity log. The Activity Director indicated an individual music activity from activity cart could be offered if the resident did not want to be involved in a group activity. She indicated there was no way to determine if resident was invited to the St. Patrick's day music program, unless the staff indicated a "R" for refused on the 17th.</p> <p>In an interview on 3/21/14 at 9:20 A.M., the Activity Director indicated she understood the documentation did not reflect the refusals of residents for some of the offered activities. She also indicated they do not generally offer pet activities.</p> <p>2. On 3/13/14 at 10:30 A.M., residents had finished an activity called "Movin and Grovin" which had started at 9:45 A.M. At 10:30 A.M., the next activity scheduled was an activity called "Exercise". Thirteen resident's were observed sitting at tables in the assist dining room. Drinks were passed out to them and music was being played. Five residents, were taken to the T.V. (television) lounge area, and music was played on the T.V. Four of the five residents had their eyes closed. Resident #8 was one of the 5 residents who were sitting in the T.V. lounge area. She was observed snoring during this activity, and no staff member was observed in the T.V. lounge area during this time. The next activity scheduled for 11:00 A.M., was "Coffee, News and Bible Trivia for Activity</p>			

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	<p>Bucks" on the 3rd floor. During the 'Coffee, News and Bible Trivia for Activity Bucks" activity this resident was left in the T.V. lounge area with the other 4 residents without a staff member present.</p> <p>On 3/13/14 at 11:15 A.M., Resident #8 was observed to remain in the lounge area with 4 other residents and music played. Three residents had their eyes closed, Resident #8 was observed snoring and 1 resident was observed trying to wheel himself out of the T.V. lounge area, no staff member was observed in the room.</p> <p>On 3/13/14 at 11:43 A.M., Resident #8 remained in the lounge area with 4 other residents. The music had stopped at 11:35 A.M., and two of the residents were awake looking around the room. Resident #8 was observed snoring and another resident had his eyes closed. No staff member was present.</p> <p>On 3/13/14 at 12:16 A.M., a CNA was observed to transport Resident #8 to the assist dining room. The resident was observed asleep and snoring. There was 4 residents at this time in the lounge area. One resident had his eyes closed and she had been snoring and two were awake looking around the room without any staff member in the room doing an activity and no music was playing.</p> <p>On 3/14/14 at 9:30 A.M., "Balloon Polo" was scheduled. Thirteen residents were observed to be in the lounge area listening to music. Resident #8 was observed sitting off to the side of the nurses station on the other side of the TV lounge area, sitting in the hallway snoring. No staff member was</p>			

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	<p>present. A staff member came into the room at 9:35 A.M., and started a balloon toss with the residents. This resident remained in the hallway across from the nurses station, away from the lounge area snoring, and laying back in her broda chair.</p> <p>On 3/14/14 at 10:00 A.M., CNA #15 was observed to transport the resident from in front of the nurses station to her room and placed into bed.</p> <p>On 3/17/14 from 9:45 to 10:07 A.M., 5 residents including Resident #8 was observed in the T.V. lounge. The T.V. was observed on with no sound, the screen was black with a message that read "No Signal." Resident #8 was observed snoring and another resident had his eyes closed and 3 other residents were looking around the room. No staff was present in the room. At 10:07 A.M., an activity staff member arrived in the T.V. lounge and turned on the T.V. to a music channel.</p> <p>Resident #8's record was reviewed on 3/14/14 at 10:55 A.M. Diagnoses included, but were not limited to the following: chronic schizoaffective disorder, failure to thrive, dementia and debility.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/14, indicated she was unable to participate in the Brief Interview for Mental Status. The resident's Decision making was severely impaired. She had short and long term memory problems.</p> <p>A document titled "Quality of Life Quarterly Assessment," dated 1/29/14, indicated the resident's leisure preferences were "Exercise, Coffee Social, crafts, socializing,</p>						

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	<p>music, movies, current events, church, bible study, parties, TV, popcorn, cooking club, manicures, Red Hat (passive participant)." The new interests for this resident this quarter indicated "Manicures, Red Hat, Sweet Shop, Live Entertainment."</p> <p>The resident had a Care Plan dated 1/29/14 that addressed the problem of at risk for social/leisure scarcity related to current medical diagnoses she needs to engage in therapeutic recreational activities based on personal leisure preferences and activity interests to enhance overall quality of life on a daily basis including, but not limited to, ice cream social, bingo, church services, trivia, reminiscing, sweet shop, manicures, current events, red hat, movies, TV aroma, tactile and visual.</p> <p>Interventions included, but were not limited to the following; "1/29/14--Provide resident with monthly calendar of recreational events, Encourage resident to Participate in activities of Interest...Escort resident to and from Activities as needed daily...Provide cues/prompts to facilitate active participation, Provide tactile stimulation, Provide a variety of music...Encourage memory stimulating activities."</p> <p>The resident had a Care Plan dated 3/5/13 with a revision date of 1/29/14 that addressed the problem of cognitive loss/dementia related to Alzheimer's and schizophrenia. Interventions included, but were not limited to the following: "Revision date 1/29/14- -...Encourage participation in activities of interest/enjoyment...."</p> <p>The "Daily Activity/Recreation Participation Log" dated for March 2014 had no</p>			

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	<p>documentation the resident had attended the following activities for this month: Arts & Crafts, Bingo, Entertainment/Special Events and Sensory Stimulation/Manicures.</p> <p>The "Daily Activity/Recreation Participation Log," dated for March 2014, had a few documented times of participation for the following activities. There were no refusals marked for the other days: Resident #8 passively participated in Spiritual/Religious activities two times this month on 3/9/14 and 3/16/14. Resident #8 passively participated in Trivia/Reminiscing one time this month on 3/13/14.</p> <p>During an interview on 3/18/14 at 10:30 A.M., the Activity Director indicated " I" was for independent, " P" was for passive, "A "was for active. She indicated if the resident's eyes were closed they could still be passively participating in the activity. She indicated if the resident was asleep the staff was to arouse the resident and if they were unable to arouse the resident than the aides were to place the resident to bed. She indicated Sensory Stimulation was when the music or the TV was played in the lounge (TV room) or 1:1 activities was completed in the rooms with the residents. The Activity Director indicated Resident #8 participated in 2-3 activities per week and the resident had participated in 2-3 activities this week . She indicated she personally stimulated Resident #8 this week and woke her up and she did participate in the activities. The Activity Director indicated she could not wake Resident #8 up for one of the activities, so she had the CNA lay her down during the activity. She indicated that music will also be</p>			

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F000250 SS=D	<p>documented as socializing.</p> <p>The Activity Director indicated if the residents were in the TV room and another activity was going on in the assist dining room, than that activity was not appropriate for the residents. She indicated if the residents were in the TV lounge listening to music for sensory stimulation, then that was not a scheduled activity at that time. She indicated that the "Rise and Shine Music" activity was when the staff gathered the residents to the dining room for the activities and the music was played in the assisted dining room and the TV lounge while the staff gathered the residents. The Activity Director indicated each music activity in the TV room only lasted for 15 minutes indicating the music played for 15 minutes then shut off.</p> <p>During an interview on 3/21/18 at 9:30 A.M., the Activities Director indicated when a resident refused an activity there was to be an "R" for "refused" in the documentation. She indicated a manicure was a hand massage and did not always mean the resident's nails were polished with nail polish.</p> <p>3.1-33(a) 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review the facility failed to follow up with medically related social services for a resident showing aggressive behavior towards staff and for 2 residents with abuse</p>	F000250	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?				

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	<p>allegations. This deficient practice affected 3 of 3 residents reviewed for medically related social service needs. (Residents C, #13, and #93)</p> <p>Findings include:</p> <p>1. On 3/21/2014 at 10:15 A.M., Resident C was observed in his room with a half full urinal on his bedside table. A folded zippered pillow case with several brown like substances or stains was under his right thigh and knee area. Oxygen tubing was on the floor of the left side of his bed and multiple cords near it. The sterile water bag attached to his oxygen tubing on one side and tubing to his tracheostomy on the other was sitting on the floor. His tracheostomy dressing was damp and yellowish tinge mucus was coming through to the right side. There was redness on the skin on the exposed skin near the dressing to his tracheostomy in the middle. The resident's right leg was uncovered with no foot coverings to his foot as he was wearing a hospital type gown. On the left side of his bed on the floor trash was scattered near an almost full trash can.</p> <p>In an interview at this time, the resident indicated that his urinal does not get emptied regularly. There have been times he has had to wait on respiratory treatments. He indicated he does not get the care he needs.</p> <p>On 3/21/2014 at 10:30 A.M., Consultant #4 indicated the resident had behaviors towards staff which made for a difficult situation.</p> <p>Resident C's record was reviewed on 3/21/2014 at 11:00 A.M. Diagnoses included, but were not limited to a history of a stroke in</p>		<p>Resident 93 has discharged from the facility since the time of this survey.</p> <p>Resident C and Resident 13 have had thorough review of their medically related social service needs by a hired outside consultant. Care plans have been updated as indicated.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents with medically related social service needs have the potential to be affected by the alleged deficient practice. A complete audit was performed to identify any residents showing aggressive behavior towards staff within the last three months. A complete audit was performed to identify any residents with abuse allegations within the last three months. Necessary medically related social services were provided or ordered as identified.</p>	

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	<p>2002 affecting his left side, respiratory complications, generalized pain, constipation, chronic airway obstruction, history of an old heart attack, hypothyroidism, asthma, depressive disorder, esophageal reflux, diabetes, mood disorder and anxiety disorder.</p> <p>An initial Social Service assessment, dated 2/11/14; indicated the resident was originally admitted from the hospital on 12/30/13 and returned to the hospital on 1/28/14. He returned back to the facility on 2/4/14. The assessment indicated "Resident is a long term placement and full code. He continues to be alert and oriented to all spheres, able to use the call-light to make his needs known. He can be very polite friendly and cooperative but at the drop of a dime he can change his personality. Today he has been verbally abusive to female staff of color [staff who provide direct care]. To writer who is a person of color he has been respectful. [Resident's name] puts on his call-light and then when staff comes, he says he wants some one else." The Social Service assessment continued explaining that the resident called a family member and stated staff was not answering his call light and that he was having difficulty breathing. The family member called the facility concerned. The SSD(Social Service Director) went and observed the resident and checked periodically throughout the rest of the afternoon and noted that the resident was frequently placing call-light on and that staff was answering it.</p> <p>A "Social Service Assessment," dated 2/18/14, indicated under additional comments:"... States he did not know why he did things but thought it was because he was</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Social Service Director quoted in this report has resigned her position. A hired outside social services consultant will follow up with the medically related social services until an appropriate replacement fills the vacant position.</p> <p>Residents with medically related social service needs will be identified in the morning clinical review process. An audit will be completed to track any residents identified as requiring medically related social service needs to indicate timely provision of these services. This audit will be entitled "Provision of Social Services".</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p>	

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	<p>missing his mother. Writer counceled on grief and loss issues and how the sense of loss will always be with him but lashing out at others has not made him feel better and it never will. Writer discussed coping options of during times of what seems to be an overwhelming sense of grief, he should focus on the good times and the blessings he had in having a positive role model in his mother. Resident was more at peace. When writer exited he ask if writer would come and talk to him again. Behaviors ceased for the rest of the afternoon."</p> <p>No follow up was located in the resident's record. During an interview on 3/21/14 at 11:21 A.M., the SSD (Social Service Director) indicated she had not been able to follow up on Resident C because her work load was significant. She indicated there use to be 2 staff in Social Service Department for the facility, but now there was just one and she was doing the best she could.</p> <p>2. Resident #93's record was reviewed on 3/14/14 at 3:41 P.M. Diagnoses included, but were limited to, cerebrovascular disease and depression.</p> <p>The Quarterly Minimum Data Set assessment, dated 1/7/14, indicated his Brief Interview for Mental Status was 13 (13-15 indicated cognitively intact).</p> <p>During an interview on 3/11/14 at 3:17 P.M., Resident #93 indicated he asked LPN #9 for a blanket on night shift on 3/10/14 before 6:00 A.M. He indicated LPN #9 told him to, "Go to sleep. Everyone else is asleep." "If</p>		<p>The "Provision of Social Services" audit will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>you don't go to sleep I am coming back with the medicine and you are taking it." He indicated she came back with medication. When he asked what the medication was for, she told him, "To quiet you down." He indicated he told LPN #9 he did not want the medication, but she "shoved" the medication down his throat. He indicated the nurse placed the spoon in the right corner of his mouth and "shoved" the spoon to the front of this mouth where his teeth were and she pushed down on the plastic spoon in his mouth forcefully to get the medication off the spoon. She had not placed her hands on him anywhere while she "shoved" the medication down his throat. He indicated he had no choice, but to swallow the medication, but he did not want the medication. He indicated he had asked for juice after the medication and she gave him a little amount of juice after the medication.</p> <p>Resident #93 indicated he had told two "workers" about the incident with the medication. The resident notified CNA #10 and CNA #11 when they transferred him into the bed after lunch. He indicated he asked the CNA's if the nurse could make him take medication that he did not want to take. He was told by the CNA's that the nurse could not make him take medication he did not want. He indicated he did not feel like he should have to fight the nurse and spit the medication out, so he swallowed it. He indicated if she would force medications onto him, he was concerned she would do that to others who could not speak out for themselves. He indicated he did not understand why she would make him take medication he did not want. He indicated, "I can't believe nurses in your profession treat human beings like this."</p>			

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	<p>During an interview on 3/11/14 at 5:30 P.M., the Executive Director (ED) indicated he and the Social Service Director (SSD) had interviewed the resident regarding the abuse allegations.</p> <p>The Social Services progress notes indicated there was no documentation found to indicate the Social Service Director (SSD) followed up with the resident after the abuse allegation to evaluate his emotional status.</p> <p>During an interview on 3/18/14 at 11:50 A.M., the Social Services Director (SSD) indicated after an abuse allegation she tried to find out what was going on with the resident and make him feel safe. She indicated there was to be an investigation and follow-up completed. She indicated the follow-up she completed with the residents can go in different directions depending on what type of abuse and the needs of the residents. She indicated she documented the follow-up of the residents emotional status in the Social Service section of the chart. She indicated if she completed some form of investigation of the abuse allegation, she completed it on a grievance form and gave it to the Administrator. She indicated she did not speak to this resident about the abuse allegation or his emotional status afterwards. She indicated she observed him for a couple of days after the abuse allegation, but she did not document the observations anywhere in his chart.</p> <p>3. Resident #13's record was reviewed on 3/13/14 at 2:00 P.M. Diagnoses included, but were not limited to chronic pain syndrome and intellectual disabilities.</p>			

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F000279 SS=D	<p>The resident's Annual Minimum Data Set assessment dated 1/9/14 indicated the Brief Interview for Mental Status was 4 (0-7 indicated severely cognitively impaired).</p> <p>A nurses note dated 11/10/13 at 8:00 P.M., indicated a family member was told by the resident a male employee had touched her on her breast inappropriately during the past week. The note indicated the Unit Manager (Weekend Supervisor) and Director of Nursing (DoN) were notified at that time.</p> <p>The Social Service progress notes dated 11/12/13 had no indication that the SSD was notified and did any follow-up on the sexual abuse allegation or the resident's emotional status.</p> <p>During an interview on 3/18/14 at 11:50 A.M., the Social Services Director (SSD) indicated after an abuse allegation she tried to find out what was going on with the resident and make her feel safe. She indicated there was an investigation and follow-up completed. She indicated the follow-up she completed with the residents can go in different directions depending on what type of abuse and the needs of the residents. She indicated she documented the follow up of the residents emotional status in the Social Service section of the chart. She indicated she did not speak to this resident about the abuse allegation or her emotional status afterwards. She indicated she did not follow-up with this resident after the sexual abuse allegations.</p> <p>3.1-34(a)(1) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE</p>						

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	<p>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 observation, interview and record review, the facility failed to develop comprehensive plans of care for a resident with right arm pain, for a resident with painful gums and a resident needing a dressing change to a painful burn. This deficient practice affected 3 out of 30 residents reviewed for comprehensive care plans. (Residents #3, #102 and #6).</p> <p>Findings include:</p> <p>1. The record review for Resident #3 was completed on 3/14/14 at 2:00 P.M. Diagnoses included, but were not limited to, heart failure, high blood pressure, stroke, and dementia.</p> <p>The quarterly MDS (Minimum Data Set)</p>	F000279	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The care plan was developed in regard to right arm pain for Resident 3.</p> <p>The care plan was developed care plan in regard to the burn for Resident 6.</p>	04/20/2014

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	<p>assessment, dated 2/6/14, indicated the resident had severe cognitive impairment but was able to verbally report her pain, and had received PRN (as needed) pain medication.</p> <p>On 3/10/2014 at 3:20 P.M., the resident was observed to have a furrowed brow, with a pained expression on her face. The resident's right arm was observed to be wrapped in an ace bandage, propped up on a pillow. Her right hand had a 2-3 plus edema.</p> <p>In an interview on 3/13/14 at 11:55 A.M., the resident indicated her right arm hurt. The arm was wrapped in bandage, and was draped across her upper abdomen. The resident's right hand had a 2-3 plus edema.</p> <p>The Medication Administration Record indicated the resident had received Hydrocodone (a pain medication) 5 mg. (milligrams) for pain on the following dates: January 2014: 1/3 (times 2), 8, 9, 13, 15 (times 2), 16, 19, 20, 22, 23, 24, 27, and 30. February 2014: 2/1, 2, 4, 6, 9, 18, 20, 25, 27, ad 28. March 2014: 3/4, 6, 8, 10 and 11.</p> <p>On 3/17/14 at 4:00 P.M., Nurse Consultant #3 was given the opportunity to provide a written Care Plan addressing the resident's pain.</p> <p>In an interview on 3/18/14, the MDS Coordinator indicated the quarterly assessment pain management tool indicated the resident was not having pain. A Care Plan would not have been initiated.</p>		<p>The dental care plan was developed for Resident 102.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>A complete audit was conducted to identify any residents receiving pain medication. A complete audit of care plans was completed for any residents reporting, exhibiting, or being treated for symptoms of pain.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Staff were re-inserviced regarding initiating or updating pain care plans</p>	

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	<p>2. Resident #102's record was reviewed on 3/14/14 at 3:05 P.M. Diagnoses included, but were not limited to, anemia and chronic pain.</p> <p>The resident's Physicians orders included, but were not limited to the following: 10/25/13-Annual Dental Evaluation as Indicated</p> <p>The "Nursing Admission Assessment" dated 9/13/13 indicated the resident had poor dentition.</p> <p>On 3/11/14 at 1:45 P.M., the resident's upper gums was observed to have broken pieces of teeth in the gums. He had other missing teeth in the upper gums.</p> <p>During an interview on 3/11/14 at 1:45 P.M., the resident indicated his teeth broke off into his gums. He indicated he had upper and lower gum pain. He indicated if he stayed still and rested for awhile, the pain would let up.</p> <p>The dental progress note dated 10/14/13 indicated the resident had missing and broken teeth to the upper and lower gums. The note indicated the resident was not a candidate for perio scaling. The next visit will have scaling scheduled.</p> <p>The dental progress notes dated 2/17/14 indicated the resident had missing teeth and broken teeth to the upper and lower gums. The note indicated he will be scheduled for a 90 day scaling. The perio chart indicated the resident had teeth located from 20-29.</p> <p>There was no Care Plan found in the resident's clinical record for Dental problems as of 3/14/14 at 3:05 P.M.</p>		<p>as needed. Orders will be reviewed in the daily clinical management meeting, and nursing management will ensure that care plans are in place for any residents with new orders for pain medication.</p> <p>A "Pain Care Plan" audit form will be initiated to validate the completion of pain related care plans.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The "Pain Care Plan" audit form will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>During an interview on 3/18/14 at 11:25 A.M., the Director of Nursing indicated the resident did not have a dental Care Plan at this time.</p> <p>3. Resident #6's record was reviewed on 3/14/14 at 4:46 P.M. Diagnoses included, but were not limited to, acute pain and second degree burn of the skin.</p> <p>A nurses note dated 3/7/14 at 3:30 P.M., indicated the resident sustained burns to his chest while in activities. He grabbed for another resident's coffee and spilled it on him. During the assessment of the resident 7 fluid filled blisters were found on his chest from his right shoulder to his groin.</p> <p>A Physician progress note, dated 3/11/14, indicated the resident had a second degree burn and he appeared in pain. The Nurse Practitioner indicated when the dressing was removed it "Caused severe pain and tearing open of skin."</p> <p>The resident's March 2014 Medication Administration Record (MAR) Physician orders included, but were not limited to the following: 3/07/14-Silver Sulfadiazine 1% topical cream (topical anti-infective medication for burns) Apply 1 gram by topical route 2 times per day (D/C 3/12/14) 3/11/14-Cephalexin (An antibiotic medication) 500 mg capsule Give 1 capsule by oral route every 6 hours for 14 days. 3/12/14-Lidocaine (A topical numbing medication) 5% topical ointment Apply by topical route 2 times per day to affected area on chest 10 minutes prior to treatment 3/12/14-Silver suladiazine 1% topical cream Apply 1 gram by topical route 2 times per day</p>			

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F000282 SS=E	<p>then cover with non-adherent telfa pad 3/16/14-Xeroform Petrolatum Dressing (A vaseline gauze with iodine) 5" x 9" Apply by topical route as one dose and cover with dry gauze for treatment of burns.</p> <p>3/18/14-Hydrocodone 5mg-Acetaminophen 325 mg (Narcotic pain medication) give 1 tablet by mouth every 6 hours for pain</p> <p>There was no Care Plan found in the resident's clinical record for burns or pain as of 3/14/14 at 4:46 P.M.</p> <p>During an interview on 3/17/14 at 12:10 P.M., the Nurse Consultant #3 indicated, when a care plan for burns and pain was requested, "I think there may be one in his chart with today's date."</p> <p>3.1-35(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to follow care plans and physician's orders for a resident after a fall, for oxygen monitoring, for lack of hygiene care and not following the sliding scale for insulin usage. This deficient practice affected 5 out of 30 residents reviewed for following care plans. (Residents B, #3, #8, and #67).</p> <p>Findings include:</p>	F000282	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The 2567 survey report reflects 5 residents affected but only identifies 4.</p>	

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	<p>1. On 3/13/2014 at 2:22 P.M., Resident B's record was reviewed. Diagnoses included, but were not limited to, osteoarthritis shoulder region, anemia in chronic kidney disease, hypothyroidism, hypertension and diabetes.</p> <p>On 3/18/2014 at 2:30 P.M., record review indicated there was a fall report on this resident dated 3/14/14 at 11:15 A.M. The report indicated the resident was attempting to get in a wheel chair from the bed but was caught by housekeeping staff who assisted the resident to the floor. One set of vital signs were recorded but the report was not signed nor was there any indication of a follow up in any way.</p> <p>The facility's Fall Management Policy and Procedure, dated October 2010, indicated, "... procedure for responding to a fall: observe condition for a minimum of 72 hours. Document pertinent details and notifications. Review, revise, and update care plan accordingly"</p> <p>In an interview on 3/18/2014 at 2:30 P.M., Consultant #4, indicated there were no other vital signs or other follow up information on this resident's fall. She indicated there was no follow up for this fall.</p> <p>Resident B's current March 2014 physician's orders indicated the resident is to have oxygen per nasal cannula; Titrate up to 3 Liters to keep oxygen sats > 90 percent.</p> <p>On 3/17/14 at 6 P.M., nurse's notes indicate the residents oxygen sats were 87 percent and "Resident normal sat range is 85 percent to 87 percent." The record lacked documentation that oxygen saturation levels were being monitored as ordered and that</p>		<p>Resident B has not had any falls since the noted occurrence. Her care plan was reviewed and revised as indicated.</p> <p>Resident 3 has had her care plan reviewed and revised to indicate current activity preferences and capacity.</p> <p>Resident 8 has had her care plan reviewed and revised to indicate current activity preferences and capacity.</p> <p>Nursing staff has been re-educated regarding insulin administration in order to prevent recurrence of the alleged deficient practice associated with Resident 67.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient</p>	

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	<p>oxygen was being administered as ordered.</p> <p>In an interview on 3/21/14 at 11:50 A.M., Consultant #4 indicated there were no oxygen saturation monitoring records found for this resident or a record of oxygen being administered for this resident.</p> <p>2. The record for Resident #3 was reviewed on 3/14/14 at 2:00 P.M. Diagnoses included, but were not limited to, heart failure, high blood pressure, stroke, and dementia.</p> <p>On 3/10/2014 at 3:19 P.M., the resident was observed in bed and the television set was turned on.</p> <p>On 3/13/14 from 10:25 A.M. through 11:55 A.M., while group activities of music and bible quiz were being conducted by the facility Activity Department in another part of the building, the resident was observed to be in bed.</p> <p>On 3/14/14 at 10:40 A.M., the resident was observed to be in bed. A group activity of "Exercise" was being conducted by the Activity Department at that time in another area of the building.</p> <p>On 3/17/14 at 9:04 A.M., the resident was laying in bed, watching television. There was music playing in the lounge area on the 3rd floor at 9:09 A.M.</p> <p>In an interview on 3/17/14 at 4:15 P.M., the resident indicated she had not participated in the St. Patrick's Day party because she had not been invited.</p>		<p>practice. An audit of activity care plans was completed to ensure that activity needs are being met.</p> <p>An audit was completed to identify residents with orders for oxygen saturation monitoring. Nursing management or their designee will perform random audits twice weekly to ensure physicians' orders for oxygen saturation monitoring are being followed.</p> <p>An audit was completed to identify residents with orders for sliding scale insulin. Nursing management or their designee will perform random audits twice weekly to ensure physicians' orders glucose monitoring and sliding-scale insulin administration are being properly followed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Nursing staff have been re-educated regarding oxygen monitoring, post-fall monitoring, provision of</p>	

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	<p>The activity Care Plan, dated 2/6/14, indicated the resident would participate in 2-4 activities a week, and these could include: Manicures, Bible Study, Sweet Shop, exercise, games, live music, as well as a variety of music such as Jazz, Gospel, and Occasional Holiday Music.</p> <p>There was no indication of interests relating to pet visits, outside activities or sewing which were listed as very important in the resident initial activity assessment.</p> <p>The March activity calendar for the facility indicated there were manicures offered on March 6th and 13th. The Sweet Shop activity was on the 4th and 11th. There was not documentation the resident attended, was offered or refused activities.</p> <p>3. Resident #8's record was reviewed on 3/14/14 at 10:55 A.M. Diagnoses included, but were not limited to the following: chronic schizoaffective disorder, failure to thrive, dementia and debility.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/14, indicated she was unable to participate in the Brief Interview for Mental Status. The resident's Decision making was severely impaired. She had short and long term memory problems.</p> <p>The resident had a Care Plan dated 1/29/14 that addressed the problem of at risk for social/leisure scarcity related to current medical diagnoses she needs to engage in therapeutic recreational activities based on personal leisure preferences and activity interests to enhance overall quality of life on</p>		<p>hygiene care and insulin administration per sliding scale. Quality Assurance Rounds were initiated for management staff to screen all residents on a regular basis for good hygiene.</p> <p>Nursing management or their designee will perform three random audits twice weekly to ensure physicians' orders for oxygen saturation monitoring are being followed.</p> <p>Nursing management or their designee will perform three random audits twice weekly to ensure physicians' orders for insulin administration are being followed.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The Quality Assurance Rounds will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>a daily basis including, but not limited to, ice cream social, bingo, church services, trivia, reminiscing, sweet shop, manicures, current events, red hat, movies, TV aroma, tactile and visual.</p> <p>Interventions included, but were not limited to the following; "1/29/14--Provide resident with monthly calendar of recreational events, Encourage resident to Participate in activities of Interest...Escort resident to and from Activities as needed daily...Provide cues/prompts to facilitate active participation, Provide tactile stimulation, Provide a variety of music...Encourage memory stimulating activities."</p> <p>The resident had a Care Plan dated 3/5/13 with a revision date of 1/29/14 that addressed the problem of cognitive loss/dementia related to Alzheimer's and schizophrenia. Interventions included, but were not limited to the following: "Revision date 1/29/14- -...Encourage participation in activities of interest/enjoyment...."</p> <p>On 3/13/14 from 10:30 A.M. to 12:16 P.M., a continuous observation of activities for Resident #8 had occurred.</p> <p>On 3/13/14 at 10:30 A.M., an activity called "Movin and Grovin" had just finished which had started at 9:45 A.M. At 10:30 A.M., the next activity scheduled was an activity called "Exercise". Resident #8 was observed being transported from the assist dining room where the activity called "Exercise" was scheduled and was transported to the TV lounge area. An activity staff member started the music was on the TV than left the lounge. She was observed snoring while the music was played. No staff member was observed</p>		<p>The oxygen saturation and insulin administration audits will be completed twice weekly for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>in the TV lounge area during the time the music was played. The next activity scheduled was "Coffee, News and Bible Trivia for Activity Bucks" on the 3rd floor at 11:00 A.M. Resident #8 was observed in the TV lounge area snoring with music being played on the TV</p> <p>At 11:15 A.M., Resident #8 was observed in the TV lounge area snoring and the TV was on with music being played. No staff member was observed in the lounge. At 11:43 A.M., she was observed in the TV lounge area and the music on the TV had stopped at 11:35 A.M. She was observed snoring and no staff member was observed in the TV lounge area. At 12:16 P.M., Resident #8 was observed in the TV lounge area and no music was being played. At this time a CNA was observed to transport her to the assist dining room and sat her at a dining room table.</p> <p>On 3/14/14 at 9:30 A.M., an activity called "Balloon Polo" was scheduled to start in the TV lounge area. Resident #8 was observed sitting on the other side of the wall of the TV lounge area, in the hallway, in front of the nurses station. She was observed laying back in her broda chair snoring. No staff member was present at this time. At 10:00 A.M., CNA #15 was observed to transport the resident from in front of the nurses station in the hallway to her room and placed her into bed.</p> <p>On 3/17/14 from 9:45 A.M. to 10:07 A.M., Resident #8 was observed in the TV lounge area. The TV was on with no sound, the screen was black with a message that read "No Signal." She was observed snoring and no staff member was observed in the lounge</p>			

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	<p>area. At 10:07 A.M., an activity staff member arrived in the TV lounge and turned on the TV to a music channel.</p> <p>During an interview on 3/18/14 at 10:30 A.M., the Activity Director indicated " I" was for independent, " P" was for passive, "A "was for active. She indicated if the resident's eyes were closed they could still be passively participating in the activity. She indicated if the resident was asleep the staff was to arouse the resident and if they were unable to arouse the resident than the aides were to place the resident to bed. She indicated Sensory Stimulation was when the music or the TV was played in the lounge (TV room) or 1:1 activities was completed in the rooms with the residents. The Activity Director indicated Resident #8 participated in 2-3 activities per week and the resident had participated in 2-3 activities this week . She indicated she personally stimulated Resident #8 this week and woke her up and she did participate in the activities. The Activity Director indicated she could not wake Resident #8 up for one of the activities, so she had the CNA lay her down during the activity. She indicated that music will also be documented as socializing.</p> <p>The Activity Director indicated if the residents were in the TV room and another activity was going on in the assist dining room, than that activity was not appropriate for the residents. She indicated if the residents were in the TV lounge listening to music for sensory stimulation, then that was not a scheduled activity at that time. She indicated that the "Rise and Shine Music" activity was when the staff gathered the residents to the dining room for the activities and the music was played in the assisted dining room and the</p>			

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	<p>TV lounge while the staff gathered the residents. The Activity Director indicated each music activity in the TV room only lasted for 15 minutes indicating the music played for 15 minutes then shut off.</p> <p>During an interview on 3/21/18 at 9:30 A.M., the Activities Director indicated when a resident refused an activity there was to be an "R" for "refused" in the documentation. She indicated a manicure was a hand massage and did not always mean the resident's nails were polished with nail polish.</p> <p>4. Resident #67's record was reviewed on 3/14/14 at 3:00 P.M. Diagnoses included, but were not limited to, diabetes with type II, ischemia heart disease, and congestive heart failure.</p> <p>The March 2014, Medication Administration Record included, but were not limited to the following Physicians orders: 09/03/13-Monitor Glucose BID-Call for BS <60 or >350. 11/12/13-Novolog 100 unit/ml subcutaneous Inject BID as per sliding scale protocol. If BS <60=No Coverage 151-200=2 Units 201-250=4 Units 251-300=6 Units 301-350=8 Units 351-400=10 Units If >400 Call MD 12/16/13-Insulin Glargine 100 unit/ml Inject 29 units by subcutaneous route once daily at bedtime.</p> <p>The resident's record indicated these dosages of Novolog sliding scale insulin were given on the following dates and times: 12/22/13-6 A.M. BS 300--8 units given and 6</p>			

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F000309 SS=G	<p>units should have been given 01/16/14-5 P.M. BS 310--10 units given and 8 units should have been given 01/10/14-5 P.M. BS 150-- 0 units given and 2 units should have been given 02/28/14-5 P.M. BS 342-- 6 units given and 8 units should have been given 02/23/14-5 P.M. BS 150-- 0 units given and 2 units should have been given 02/19/14-5 P.M. BS 328-- 6 units given and 8 units should have been given 02/08/14-6 A.M. BS 212--212 units given and 2 units should have been given 03/11/14-5 P.M. BS 235--3 units given and 4 units should have been given 03/10/14-5 P.M. BS 261--4 units given and 6 units should have been given 03/09/14-5 P.M. BS 182--4 units given and 2 units should have been given 03/03/14-5 P.M. BS 222--2 units given and 4 units should have been given.</p> <p>During an interview on 3/18/14 at 11:25 A.M., the DoN indicated the sliding scale insulin was not the Nursing Standard Care of Practice and she was working with the resident's Physician to have the sliding scale discontinued. She indicated the 212 units documented as given on 2/8/14 was a documentation error due to the amount of insulin and type of insulin documented.</p> <p>3.1-35(g)(2) 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</p>			

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	<p>care.</p> <p>Based on observation, interview and record review, the facility failed to assess a resident for a significant change in condition and report critical lab values to the resident's physician, as well as obtain a urinalysis resulting in the resident's hospitalization for an infection that met the criteria for Sepsis. The facility failed to ensure a resident with a second degree burn had his pain controlled during a dressing change; failed to assess a burn wound; failed to administer pain medication to 1 of 3 residents who complained of pain; failed to monitor blood sugars and insulin scale needs. These deficient practices affected 5 of 30 residents reviewed. (Residents B, #6, #67, #3, #35).</p> <p>Findings include:</p> <p>1. On 3/11/2014 at 10:35 A.M., Resident B was observed in her room and was able to give her name and comment on the breakfast she was eating.</p> <p>On 3/12/2014 at 9:30 A.M., Resident B was observed in her room able to finish an interview and share her likes and dislikes.</p> <p>On 3/13/2014 at 10:50 A.M., the resident was observed in her room in bed with eyes closed.</p> <p>On 3/14/2014 at 6:35 P.M., the resident was observed in her room up in her wheelchair trying to eat, but short of breath and not speaking.</p> <p>On 3/16/2014 at 5:50 P.M., the resident was observed in her room sitting up in her wheel</p>	F000309	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B was admitted to the hospital and returned in stable condition while survey was still in progress. A urinalysis was no longer needed. The nurse responsible for failing to assess her change in condition and report critical lab values is no longer employed at the facility. Resident 6 has current orders for pain medication and is seen routinely for skin assessment. Treatment orders are being followed and affected area continues to heal. Nursing staff has been re-educated regarding insulin administration in order to prevent recurrence of the alleged deficient practice associated with Resident 67. A comprehensive care plan was developed in regard to right arm pain for Resident 3. A comprehensive care plan was developed in regard to leg and foot pain for Resident 35. Nursing staff has been re-educated regarding pain management in order to prevent recurrence of the alleged deficient practice associated with Residents 3 and 35. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be</p>	04/20/2014

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	<p>chair, short of breath and trying to reach and push her call light.</p> <p>On 3/17/2014 at 11:00 A.M., the resident was observed in her room in bed.</p> <p>On 3/18/2014 at 9:55 A.M., the resident was not in her room. In an interview at this time, LPN #1 indicated the resident's family requested the resident be sent out to an acute care hospital on the evening of 3/17/2014.</p> <p>Resident B's record was reviewed on 3/18/2014 at 10:00 A.M. Diagnoses included, but were not limited to, osteoarthritis shoulder region, anemia in chronic kidney disease, hypothyroidism, hypertension and diabetes.</p> <p>A "Change of Condition" SBAR [Situation, Background, Assessment, Response], dated 3/16/2014 at 10:00 P.M. indicated Resident B was verbally responsive though not able to effectively communicate as usual. "Unable to form complete words... MD response: New orders: CBC [Complete Blood Count]; BMP [Basic Metabolic Panel]; UA C&S [Urinalysis Culture and Sensitivity]."</p> <p>Blood work was drawn on 3/17/2014 at 6:27 A.M. Results of lab work were faxed to the facility at 12:45 P.M., because the lab was "unable to reach nurse by phone." The lab indicated the resident's blood glucose level was 33 mg/dL with the reference range of 64 - 112 indicating a critically low level. The WBC (white blood cell count) was 15.5 x 10³/uL with the reference range being 4.2-10.0 indicating a high level. The record indicated the lab results were not called to the Physician. A late entry made on 3/18/14 at 12:20 P.M.,</p>		<p>affected by the alleged deficient practices. A complete audit was immediately initiated to identify any residents with unaddressed critical labs or changes in condition. No new concerns were identified. A complete audit was conducted to identify any residents receiving pain medication. A complete audit of care plans was completed for any residents reporting, exhibiting, or being treated for symptoms of pain. An audit was completed to identify residents with orders for sliding scale insulin. Any identified issues were addressed with corresponding nursing staff.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? Nurses were re-educated regarding the reporting of critical lab values to the physician. Nurse management has implemented a lab tracking system to ensure that labs are obtained as ordered and results are addressed as indicated. Nurse management will ensure prompt and appropriate physician notification of critical labs. Staff were re-educated regarding initiating or updating pain care plans as needed. Orders will be reviewed in the daily clinical management meeting, and nursing management will ensure that care plans are in place for any</p>	

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	<p>for 3/17/14 at 6 P.M., indicated the resident's family requested she be sent out as she was " not herself." Vital signs taken at that time indicated the following: " BP[blood pressure] 130/70, P[pulse] 95, R[respirations] 19, Sat [oxygen saturation] 87 percent, T [temperature] 100.9 Fahrenheit."</p> <p>During an interview with Nurse Consultant #3 on 3/18/14 at 3:40 p.m., she indicated the Urinalysis had not been completed due to "they didn't have time." The Urinalysis was ordered on 3/16/14 at 10 p.m., and the resident was not sent to the hospital until the evening of 3/17/14.</p> <p>The (name of hospital) acute care hospital record for Resident B was reviewed n 3/18/14 at 2:30 P.M. The hospital's "AIMS history and physical" record dated 3/17/14 indicates the resident was found to have altered mental status, her blood sugar was 51 mg/dL, her white blood count was significantly elevated, and a urinalysis was found to show the resident had a marked number of bacteria in her urine and met the criteria for Sepsis (a potentially life threatening complication of an infection).</p> <p>On 3/18/14 at 4:10 p.m., Consultant # 4 indicated the Nurse Practitioner was not notified of the critical blood sugar level or the high white blood cell count until the resident was sent to the hospital. She indicated the Urinalysis had not been completed and there was no documentation it was attempted. She also indicated the residents physician was in the facility the day on 3/17/14, but he had not seen the resident.</p> <p>2. A. Resident #6's record was reviewed on 3/14/14 at 4:46 P.M. The diagnoses</p>		<p>residents with new orders for pain medication. Nursing management or their designee will perform random audits twice weekly to ensure physicians' orders glucose monitoring and sliding-scale insulin administration are being properly followed. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Nursing management or their designee will perform three random audits twice weekly: (1) to ensure physicians' orders for insulin administration are being followed, (2) to ensure critical lab values are reported to the physician in a timely manner, and (3) to ensure pain medication is made available for those residents reporting or exhibiting signs of pain. These audits will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>included, but were not limited to, the following: depressive disorder, debility, anxiety state, acute pain and second degree burn of the skin.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 1/22/14 indicated the resident's Brief Interview for Mental Status (BIMS) was 6 (0-7 indicates severely cognitively impaired). The pain assessment indicated he did not receive scheduled pain medication or PRN (as needed) pain medication. He did receive non medication interventions for pain. The assessment indicated he denied having any pain during the assessment period.</p> <p>During an activity on 3/7/14 at 11:00 A.M., the resident reached for another resident's coffee during an activity and spilled it on his chest and abdomen.</p> <p>During a dressing change observation with LPN #16, on 3/14/14 at 5:08 P.M., the resident was observed to have a burned area from his right collar bone area down his chest and abdomen into the right suprapubic area. The right collar bone area was beginning to scab. The skin was peeled off the entire area. The mid abdominal area and under the G-tube area had 6 areas with yellow slough tissue (dead tissue covering the wound bed). The outer side of the mid abdominal area had a pea size area that was actively bleeding with a small amount of blood when the telfa dressing was removed. The old telfa dressing had a small amount of serous (yellow colored) drainage on it. The resident stated, "Oh s---" the entire time the telfa dressing was being removed. The resident repeated "Oh s---" the entire time LPN #16 was observed applying the</p>			

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	<p>Lidocaine ointment (a topical numbing medication). Resident #6 stated, "I guess I am going to die" while LPN #16 was applying the lidocaine ointment. He gritted his teeth moving his jaw back and forth through the entire time the Lidocaine was being applied.</p> <p>On 3/14/14 at 5:33 P.M., LPN #16 was observed to apply Silver Sulfadiazine 1% topical cream (an anti-infective medication for burns) with 4 x 4 gauzes. The resident was yelling out 'Oh s---, G-- D--- it" repeatedly while the nurse applied the cream. When she applied the medicated cream under the G-tube dressing he yelled out "Oh s---, G-- D-- it, B----" After the application of the medicated cream, she applied long telfa pads to the burn wounds. The resident gritted his teeth together while he moved his jaw back and forth during the entire dressing change</p> <p>A. A Physician progress note, dated 3/11/14, indicated the resident had coffee spilled on him over the weekend. The note indicated the resident had a second degree burn from the left shoulder through the chest and abdomen area into the suprapubic area and he complained of severe pain and discomfort. The note indicated the resident appeared in pain, there was a burn, he was awake and alert, anxious and agitated and he could follow simple commands. The wound had a regular dressing secured with tape instead of a non-adherent dressing on it and the note indicated when the dressing was removed it "Caused severe pain and tearing open of the skin. Debridement was required by the Nurse Practitioner. The resident was given 5 mg (milligrams) of Morphine (a narcotic medication) intramuscularly when the Nurse Practitioner noted the condition of the wound</p>			

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	<p>and then again with the dressing change on 3/12/14.</p> <p>A Physician's progress note, dated 3/12/14, indicated the resident appeared in pain, had a burn, was awake, alert and oriented, was anxious and agitated and he could follow simple commands. His blood pressure was 154/84. The note indicated the resident had a diagnosis of acute pain and he was being prescribed Norco (pain medication) 5/325 mg give 1 tablet every 6 hours times 5 days and give 30 minutes before the dressing change and 1 tablet every 6 hours as needed for pain, but do not fill before 3/18/14. The Nurse Practitioner indicated Resident #6 had a diagnosis of second degree burn of skin and he was to receive Lidocaine topical ointment 5% to be applied twice a day to the affected areas ten minutes before the dressing change.</p> <p>During an interview on 3/17/14 at 11:26 A.M., the Nurse Practitioner indicated she did not order routine pain medication prior to dressing changes due to the resident had never been on anything stronger than Tylenol and that was why she made the Hydrocodone order PRN. She indicated she made 3/18/14 as the start date instead of the end date. She indicated she had intended for the end date to be 3/18/14.</p> <p>The March 2014 Medication Administration Record Physician orders included, but were not limited to the following: 10/24/13-Acetaminophen 160 mg (milligrams)/5 ml (milliliters) oral liquid Give 20.3 ml (650 mg) via G-tube every 4 hours as needed for pain. 10/24/13-Tylenol 325 mg tablet Give 2 tablets (650 mg) by oral route every 6 hours as</p>			

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	<p>needed for pain.</p> <p>03/11/14-Morphine 1 mg/ml Inject 1 milliliter (1 mg) by injection route as one dose.</p> <p>03/11/14-Morphine 10 mg/ml Infuse 5 milligrams by injection route now.</p> <p>3/12/14-Morphine 10 mg/ml Give 5 milligrams (mg) by injection route as one dose 30 minutes prior to dressing change today.</p> <p>03/18/14-Hydrocodone 5 mg-Acetaminophen 325 mg (Narcotic pain medication)tablet Give 1 tablet by mouth every 6 hours for pain.</p> <p>During an interview on 3/14/14 at 5:08 P.M., LPN #16 indicated she had not taken care of the resident since he had gotten the blistering. She indicated the Lidocaine ointment was ordered to be placed on the burn before the dressing change to numb the area, so the Silvadene cream could be applied without discomfort. She indicated the resident did not need an oral "as needed" pain medication due to he had the Lidocaine ointment she applied to numb the areas before she applied the Silvadene cream.</p> <p>During an interview on 3/14/14 at 5:14 P.M., the resident indicated the wound "Hurts all the time, but they don't listen to me."</p> <p>During an interview on 3/17/14 at 2:21 P.M., CNA #15 indicated the resident was sore in his chest area when staff turned him. She indicated he would state, "Ouch."</p> <p>During an interview on 3/17/14 at 3:40 P.M., LPN #16 indicated when she did the resident's dressing change on 3/14/14 and he was complaining of pain during the dressing change, she should have stopped, given him pain medication, allowed the pain medication to become effective, then attempted the</p>			

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	<p>dressing change again.</p> <p>During an interview on 3/17/14 at 5:50 P.M., the Director of Nursing (DoN) indicated she expected the nurses to evaluate a resident for pain before a dressing change. She indicated she expected the nurses to premedicate the resident if the resident was having pain, talk to another nurse who had completed the dressing change before and ask about the resident's pain with dressing changes and if the resident required premedication before the dressing change, then premedicate the resident. She expected the nurses to stop the dressing change if the resident showed signs and symptoms of pain or complained of pain and medicate the resident, provide time for the medication to become effective, then continue with the dressing change.</p> <p>During an interview on 3/21/14 at 10:00 A.M., Consultant #4 indicated the dressing change completed on 3/14/14, should have been stopped and the resident should have been medicated, the nurse should have allowed the pain medication to become effective, then the dressing change could have been completed.</p> <p>A current policy titled "Covenant Care Skin Integrity Standard" date June 2010, provided by Consultant #3 on 3/17/14 at 3:30 P.M., indicated "...Assessment of pain is critical...As well, pain assessment results may indicate the need for pain medication prior to wound care interventions and/or dressing changes..."</p> <p>B. The nurses notes dated 3/7/14 at 3:30 P.M., indicated the resident sustained burns to his chest while in activities. He reached</p>				

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	<p>for another resident's coffee and spilled it on him. During the assessment of the resident 7 fluid filled blisters was found on his chest from his right shoulder to his suprapubic area. The Physician's office was notified.</p> <p>A nurses note dated 3/7/14 at 9:30 P.M., indicated a new order was given for Silvadene cream to the burned area and then to cover it.</p> <p>The March 2014 Medication Administration Record indicated the following orders: 3/07/14-Silver Sulfadiazine 1% topical cream Apply 1 gram by topical route 2 times per day (Discontinue 3/12/14) 3/11/14-Cephalexin 500 mg capsule Give 1 capsule by oral route every 6 hours for 14 days. 3/12/14-Lidocaine 5% topical ointment Apply by topical route 2 times per day to affected area on chest 10 minutes prior to treatment 3/12/14-Silver suladiazine 1% topical cream Apply 1 gram by topical route 2 times per day then cover with non-adherent telfa pad 3/16/14-Xeroform Petrolatum Dressing 5" x 9" Apply by topical route as one dose and cover with dry gauze for treatment of burns</p> <p>The nurses note dated 3/8/14 at 12:00 P.M., indicated during the assessment of the burned area, the area was noted to be red and there were blisters at the abdomen that had broken and some of the areas were draining serous fluid. The treatment was completed as ordered. The note indicated there were no signs or symptoms of infection.</p> <p>The nurses note dated 3/8/14 at 10:00 P.M., indicated when the old dressing was removed, there was yellow drainage noted to two areas on the lower abdomen. The</p>			

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	<p>dressings change was completed as ordered.</p> <p>There was no documentation of measurements of the blisters or redness that were noted in the record on 3/7/14 at 3:30 P.M.</p> <p>There was no documentation of assessments of wound care for a burn wound from 3/8/14 at 10:00 P.M., until 3/11/14, when the the NP assessed the burns.</p> <p>There was no further documentation provided regarding the assessment of wound care or measurements of the blisters from 3/7/14 -3/10/14 by the end of the exit conference on 3/21/14 at 3:15 P.M.</p> <p>The Physician progress notes dated 3/11/14 indicated the resident had coffee spilled on him over the weekend. The note indicated the initial call into the Physician office stated, "Patient had reddened area near right scapula size of quarter." The note indicated the resident now had second degree burns from the left shoulder through the chest and abdomen area into the suprapubic area and he complained of severe pain and discomfort. There was serous-sanguineous and pus drainage throughout the burn wound. The wound had a regular dressing secured with tape instead of a non-adherent dressing on it and the note indicated when the dressing was removed it "Caused severe pain and tearing open of skin. Debridement was required by the Nurse Practitioner. "The note indicated the resident was started on Keflex (an Antibiotic medication) 500 mg 1 tablet by mouth four times daily for 14 days, Silvadene cream to the area of the burn generously then cover with telfa dressing (non-adherent dressing) and do not use tape</p>			

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	<p>to secure the dressing...."</p> <p>The Physician's progress notes dated 3/12/14 indicated the resident had a diagnosis of second degree burn of the skin.</p> <p>The nurses noted dated for 3/13/14 at 9:00 A.M., indicated the resident's burn measured 48.0 x 16.0 x <0.1 cm. The wound spanned from his right collar bone on the right side of the sternum down to the right superapubic area. The wound bed was reddened. The treatment was completed as ordered.</p> <p>During an interview on 3/14/14 at 4:10 P.M., the Director of Nursing indicated the resident was burned on 3/7/14 by reaching for someone else's coffee in an activity and the skin was red on 3/7/14 and 3/8/14. She indicated the skin on his chest peeled off on 3/13/14, so the wound had to be dressed with Silvasorb ointment</p> <p>During an interview on 3/14/14 at 6:30 P.M., Nurse Consultant #3 indicated she had seen the nurses notes, which indicated the resident had 7 fluid filled blisters on 3/7/14 after he was burned by the coffee. She indicated the Director of Nursing (DoN) was not given this information when she received the call from the nurse on 3/7/14. Nurse Consultant #3 indicated RN #17 assessed the wound on 3/8/14 and she did not see any blisters on the resident's chest that day and all she noted was redness. Nurse Consultant #3 indicated the nurse did not notify the DoN of the severity of the wound on 3/7/14. She indicated the nurse who assessed the resident after the burn on 3/7/14 did not complete the SBAR (Situation, Background, Assessment and Request) or measure the wound as per the policy.</p>			

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	<p>During an interview on 3/17/14 at 11:26 A.M., the Nurse Practitioner indicated she was notified on 3/7/14 the resident was burned by coffee and had reddened areas. She indicated she did not know until she came in to assess the resident on 3/11/14 that he had full blown blistering and she seen it with her own eyes. for She indicated when she took the dressing off on 3/11/14 the wound edges were dry from the Silvadene cream and when she pulled the gauze dressings off that could have caused the skin to peel off.</p> <p>3. Resident #67's record was reviewed on 3/14/14 at 3:00 P.M. Diagnoses included, but were not limited to,diabetes with type II, ischemia heart disease, and congestive heart failure.</p> <p>The March 2014, Medication Administration Record included, but were not limited to the following Physicians orders: 09/03/13-Monitor Glucose BID-Call for BS <60 or >350. 11/12/13-Novolog 100 unit/ml subcutaneous Inject BID as per sliding scale protocol. If BS <60=No Coverage 151-200=2 Units 201-250=4 Units 251-300=6 Units 301-350=8 Units 351-400=10 Units If >400 Call MD 12/16/13-Insulin Glargine 100 unit/ml Inject 29 units by subcutaneous route once daily at bedtime.</p> <p>The resident's record indicated these dosages of Novolog sliding scale insulin were given on the following dates and times: 12/22/13-6 A.M. BS 300--8 units given and 6</p>			

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	<p>units should have been given 01/16/14-5 P.M. BS 310--10 units given and 8 units should have been given 01/10/14-5 P.M. BS 150-- 0 units given and 2 units should have been given 02/28/14-5 P.M. BS 342-- 6 units given and 8 units should have been given 02/23/14-5 P.M. BS 150-- 0 units given and 2 units should have been given 02/19/14-5 P.M. BS 328-- 6 units given and 8 units should have been given 02/08/14-6 A.M. BS 212--212 units given and 2 units should have been given 03/11/14-5 P.M. BS 235--3 units given and 4 units should have been given 03/10/14-5 P.M. BS 261--4 units given and 6 units should have been given 03/09/14-5 P.M. BS 182--4 units given and 2 units should have been given 03/03/14-5 P.M. BS 222--2 units given and 4 units should have been given.</p> <p>During an interview on 3/18/14 at 11:25 A.M., the DoN indicated the sliding scale insulin was not the Nursing Standard Care of Practice and she was working with the resident's Physician to have the sliding scale discontinued. She indicated the 212 units documented as given on 2/8/14 was a documentation error due to the amount of insulin and type of insulin documented.</p> <p>4. The record for Resident #3 was reviewed on 3/14/14 at 2:00 P.M. Diagnoses included, but were not limited to, heart failure, high blood pressure, stroke, and dementia.</p> <p>The MDS (Minimum Data Set) assessment, dated 2/6/14, indicated the resident had</p>			

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	<p>severe cognitive impairment, but was able to verbally report her pain.</p> <p>On 3/10/2014 at 3:20 P.M., the resident was observed to have a furrowed brow, with a pained expression on her face. The resident's right arm was observed to be wrapped in an ace bandage, propped up on a pillow. Her right hand had a 2-3 plus edema.</p> <p>In an interview on 3/13/14 at 11:55 A.M., the resident indicated her right arm hurt. The arm was wrapped in bandage, and was draped across her upper abdomen. The resident's right hand had a 2-3 plus edema.</p> <p>In an interview on 3/13/14 at 1:54 P.M., the resident indicated her right arm still hurt.</p> <p>The day shift (7 AM to 3 PM) pain assessment on 3/13/14 at 3:15 P.M., indicated "0" for "PAIN VERBAL." There was no PRN (as needed) pain medication documented as given for 3/13/14 for 7-3 shift.</p> <p>The Medication Administration Record indicated the resident had received a PRN dose of Hydrocodone (a pain medication) 5 mg. (milligrams) for pain on 3/4, 6, 8, 10 and 3/11/14. The pain assessments for these dates had "0" (zero) for each date for pain on each shift.</p> <p>In an interview on 3/13/14 at 4:00 P.M., Nurse Consultant #3 indicated a nurse should complete a pain assessment each shift, and document the pain rating before and after a pain medication is given under the PRN medication documentation. She indicated the shift pain assessment should match the PRN pain medication given. She indicated the nurse might ask at the end of</p>			

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	<p>the shift if the resident had pain that day.</p> <p>In an interview on 3/14/14 at 9:30 A.M., Nurse Consultant #3 indicated LPN #7 told her that she (the LPN) assesses the resident's pain by asking her if it hurts "a little" or "a lot." This was how she utilized the pain scale of a numerical value such as 0 or 3. The Nurse Consultant also indicated LPN #7 told her she (the LPN) also looked for facial expression, or touched the resident's arm to see if it was tender to touch. The Nurse Consultant indicated that information should be documented in the nurses notes.</p> <p>5. The record for Resident # 35 was reviewed on 3/1/13/14 at 4:00 P.M. Diagnoses included, but were not limited to, diabetes, arthritis, and neuropathy.</p> <p>On 3/10/2014 at 3:25 P.M., the resident was heard to be making a repetitive grunting sound. In an interview at that time, the resident indicated she "hurt."</p> <p>On 3/13/14 at 11:45 A.M., the resident was observed laying in bed. The resident indicated her right foot hurt. The foot was observed to be pushed against the bottom of the footboard of the bed. She picked her foot up and placed it on top of the footboard.</p> <p>In an interview on 3/17/14 at 4:00 P.M., the resident indicated her left leg was hurting. In an interview at that time, LPN #6 indicated the resident's pain started in the last month, but she was able to verbally report to the nurses if she needed something for pain.</p> <p>The physician's orders for March 2014 included a current order (2/26/14) for Neurontin 100 milligrams by mouth three</p>			

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F000312 SS=D	<p>times daily for neuropathy (pain in lower legs and feet). There were also orders for Tylenol Arthritis Pain--Extended Release 1 tablet by mouth three times daily PRN (as needed for pain) (9/14/13), and Tramadol (a non-narcotic pain medication) 50 milligrams 1 tablet by mouth every 6 hours PRN pain (9/14/13).</p> <p>The March, 2014 MAR (Medication Administration Record) indicated no PRN pain medications had been given. The daily pain assessments indicated "0" (no pain) for all 3 shifts.</p> <p>A policy titled "Operating Standard Pain Management Process," dated 6/09, indicated "...Evaluation of pain levels through the use of a pictorial pain scale (Wong Baker faces) or numerical pain rating scale...Documenting pain assessment and effectiveness of both routine and PRN pain medication in the nurses progress notes and/or MAR every shift using scale of 0-10...."</p> <p>3.1-37(a) 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review the facility failed to provide assistance with grooming, personal hygiene and oral care for 3 out of 4 residents reviewed for assistance with activities of daily living. (Residents B, D, and #37).</p>	F000312	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	

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	<p>Findings include:</p> <p>1. On 3/11/2014 at 10:35 A.M., Resident B was observed sitting in her wheel chair in her room in a hospital type gown eating. Her hair was not combed and nails were long with some food residue underneath a couple of them.</p> <p>On 3/12/2014 at 9:30 A.M., she was observed sitting in her wheel chair in her room wearing a hospital type gown and her hair was not combed.</p> <p>On 3/13/2014 at 10:50 A.M., the resident was observed in her room in bed with her hospital type gown on and her eyes closed.</p> <p>On 3/14/2014 at 6:35 P.M., the resident was observed in her room up in her wheelchair in a night gown with uncombed hair.</p> <p>In an interview on 3/14/14 at 6:35 P.M., the resident's family member indicated she has had a significant decline in the past few weeks. He did not think anyone cared, a few do but most don't. She is always in a hospital type gown and does not look cared for.</p> <p>Record review of her January, February and March care sheets that included oral care, bathing, personal hygiene, and dressing indicated the following: January 2014 -- Bed Bath on 1/9/14 and a shower on 1/16/14. No other showers were documented. February 2014 -- She got a shower on 1/17/14 and on 1/19/14. No other showers were documented. March 2014 --She got a shower on 3/6/14. No other showers were documented.</p>		<p>Resident B, Resident D and Resident 37 have been provided with assistance with grooming, personal hygiene and oral care per their individualized preferences.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents requiring assistance with grooming, personal hygiene and oral care are at risk for the same alleged deficient practice.</p> <p>Quality Assurance Rounds were initiated and assistance was provided to those residents identified as requiring assistance with grooming, personal hygiene or oral care. Care plans were updated as identified to reflect each resident's personal preference.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that</p>	

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	<p>Resident B's ADL (Activities of Daily living) indicated she was schedule to get assistance with a shower every Monday and Thursday evening. The level of support she needed was listed as one person physical assist.</p> <p>2. The record for Resident D was reviewed on 3/17/14 at 10:52 A.M. Diagnoses included, but were not limited to, contracture of joint of multiple sites, dysphagia due to cerebrovascular disease, intellectual disabilities, chronic pain syndrome, muscle spasms, and Multiple Sclerosis.</p> <p>In an interview on 3/11/2014 at 5:25 P.M., a family member indicated she had mentioned, and left sticky notes and such, with the staff CNAs to do the resident's oral care. However, they were not doing it. The family member indicated when she asked again about the oral care, the CNAs reported the resident refused to allow them to do it.</p> <p>On 3/14/14 at 11:28 A.M., the resident was noted to have a foul breath odor.</p> <p>On 3/21/14 at 10 :45 A.M., the resident's teeth were observed to have white matter stuck in between the teeth and gums.</p> <p>The "Activities of Daily Living" sheets had boxes for "oral care" for each day of the month. A "key" on the sheet indicated documentation of a "RC" would mean "routine oral care," and documentation of a "S" would mean "special oral care."</p> <p>The resident's "Activities of Daily Living" sheets for the months of January, February</p>		<p>deficient practices do not recur?</p> <p>Nursing staff has been re-educated regarding the provision and documentation of assistance of ADL care in accordance with the resident's care plan.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The Quality Assurance Rounds will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p> <p>ADL documentation will be reviewed for completion by nursing management or their designee at least 3 times per week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>				

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	<p>and March had a line through the box for oral care for each day.</p> <p>In an interview on 3/17/14 at 3:00 P.M., Nurse Consultant #3 indicated that if the care had been provided, there would be a RC or S in each box on the ADL sheet. If there was a line through the box, that indicated the care was not done.</p> <p>3. The record for Resident #37 was reviewed on 3/14/13 at 9:00 A.M. Diagnoses included, but were not limited to, history of falls, depression, anxiety and high blood pressure.</p> <p>The MDS (Minimum Data Set) assessment, dated 1/7/14, indicated the resident was cognitively intact.</p> <p>During an interview on 3/11/14 at 2:00 P.M., the resident indicated she had not had a shower in over a week.</p> <p>On 3/12/14 at 11 A.M., the resident was observed to have greasy hair, and was wearing the same floral shirt and orange pants that she was wearing on 3/11/14 during the resident interview.</p> <p>CNA "shower sheet" forms indicated the following: 2/12/14-- the resident refused a shower. 3/8/14--nothing was documented or circled. 3/12/14--documented as shower and circled.</p> <p>The shower schedule indicated the resident received her showers on Wednesday and Saturday evenings.</p> <p>The Activities of Daily Living documentation for the resident for March 2014 indicated the resident had received a shower on 3/1/14</p>			

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F000314 SS=D	<p>and 3/12/14. The resident received a bed bath on 3/5, and 3/7/14.</p> <p>In an interview on 3/21/14 at 10:00 A.M., Consultant #4 indicated the CNA staff should document refusal on the resident's shower days if they refused a shower. She also indicated typically a bed bath does not include the hair being washed.</p> <p>This Federal Tag relates to Complaint IN00144974.</p> <p>3.1-38(a)(3) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's pressure ulcer dressing change was completed without potential for infection and the appropriate treatment and dressings were not used for a dressing change for 1 of 3 residents reviewed for pressure ulcers. (Resident #102)</p> <p>Findings include: On 3/17/14 at 3:18 P.M., RN #14 was observed to place a towel under the</p>	F000314	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Nursing staff has been re-educated in order to prevent recurrence of the alleged deficient practice.</p>	

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	<p>resident's feet, she donned a clean pair of gloves, then removed his bilateral lower leg dressings. The left lower leg dressing had a small amount of serous drainage on the outside of the old dressing. The dressing was stuck to his lower leg at the top of the leg. RN #14 used Normal Saline vials (sterile salt solution) to soak the dressing off.</p> <p>The upper part of the left lower extremity anterior pressure wound had yellow slough (dead tissue covering the wound bed) with black colored tissue around the wound. The wound appeared to be extending to the right of the left lower leg with smaller wounds with yellow slough in the wound beds. The left lateral ankle pressure wound had yellow slough that covered 50-75% of the wound bed with 25-50% pink wound bed. The periwound (the skin around the wound) was brown colored. These wounds had a foul odor when the dressing was removed. The old dressing on the inside, which covered the wounds had a small amount of serous drainage.</p> <p>RN #14 removed the old dressing from the resident's right lower leg. The dressing stuck to the upper part of the lower leg. She soaked the dressing off with Normal Saline (NS) vial. The right lower leg upper anterior pressure wound had a red wound bed with a brown periwound. The right lateral dorsal foot wound had a red wound bed with yellow slough periwound. The right heel wound was pink/red in color. The right wound dressing had a small amount of serous drainage on the old dressing. While the nurse removed the old dressing, she placed her hands in her scrub jacket pockets looking for the Normal Saline vials and placed her scissors back in her pocket with the same gloves she used to</p>		<p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents requiring clean dressing changes are at risk for the alleged deficient practice. Nursing staff have been re-educated on infection control and clean dressing changes.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Facility nurse has been sent to specialized wound care training and will supervise weekly wound rounds. Nursing staff has been re-educated and completed skills validations regarding clean dressing change procedures.</p> <p>How will the corrective action(s) be monitored to ensure the</p>	

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	<p>remove the soiled dressings off the resident's bilateral lower legs.</p> <p>RN #14 left the resident's wounds to his bilateral lower legs open to air while she went to assemble the dressing supplies at 3:30 P.M. The nurse returned into the resident's room with the dressing supplies at 3:45 P.M., and laid the supplies on the overbed table without a barrier under the dressing supplies She washed her hands. She prepared her supplies on the resident's bedside table. She left the room to go into the hallway to look at the dressing change order on the computer. She donned sterile gloves and cleansed the right upper anterior wound with NS vial, patted it dry with a 4 x 4 gauze, then covered it with an island dressing. She removed her gloves. She washed her hands and went into the hallway and reviewed the dressing change orders. She indicated there was suppose to be a moistened gauze under the island dressing. She donned clean gloves and removed the island dressing, then she placed a piece of moistened gauze on the resident's wound, then she removed her gloves. She left the room and went to the treatment cart to retrieve another island dressing, she donned sterile gloves and placed the island dressing over the moistened gauze already on the right upper anterior wound.</p> <p>The resident had an order to apply Santyl to the wound under the NS moistened gauze. The Santyl was not observed to be applied to the resident's wound before the gauze was applied and the wound was covered.</p> <p>RN #14 washed her hands. She left the resident's room and went into the hallway to review the resident's orders on the computer.</p>		<p>deficient practice will not recur?</p> <p>Dressing change observations will be completed by nursing management at least 3 times per week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>She donned sterile gloves, then cleansed the lateral dorsal right foot wound with a NS vial and patted it dry. She removed her gloves and donned a sterile pair of gloves. She cut a piece of Calcium Alginate (a dressing with an anti-infective medication) and placed it over the wound without cleansing the scissors before cutting the dressing. The nurse cleansed the right heel wound with the NS vial, patted it dry, applied skin prep (skin protective barrier wipes) around the wound, then applied a heel foam island dressing over the wound. She wrapped the right lower leg with kerlix (gauze dressing) from the toes to the knee. She took her pen out of her pocket and wrote the date and her initials on a piece of tape with the same gloves on that she dressed the resident's wound with. She removed her gloves, then went into the hallway to review the resident's order for the left lower leg on the computer. She applied a tubigrip to the resident's right lower leg.</p> <p>RN #14 was observed to cover the right lateral dorsal foot wound with Calcium Alginate and the resident had an order for Prisma dressing to this wound then wrap with dry roll gauze. The resident had an order for an ace wrap to the right leg to be wrapped from the toes to below the knees and RN #14 applied a tubigrip to the resident's right lower leg.</p> <p>RN #14 washed her hands and donned sterile gloves. She cleansed the left upper lateral anterior and left lateral ankle wounds with NS vials, then patted them dry with 4 X 4 gauzes. She placed Santyl (a medication that removes dead tissue from the wound) on all the wounds including the wound extending from the upper part of the left lower extremity anterior wound using sterile cotton tipped</p>			

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	<p>applicators. She covered the left upper anterior wound with a long telfa dressing. She removed her gloves and went to the treatment cart and got another telfa dressing at 4:23 P.M. She came back into the room at 4:28 P.M., and donned sterile gloves and placed telfa dressings on the upper left anterior wound. She removed her gloves and went back to the treatment cart. She came back with abdominal pads and kerlix. She washed her hands and donned sterile gloves. She covered the left lower leg with abdominal pads then wrapped the left lower leg with kerlix and secured it with tape. She reached into her scrub jacket pocket with the same gloves she used to dress the lower left leg and took out her pen and dated and initialed the tape, then placed the pen back into her pocket.</p> <p>The resident had an order for Zinc to the left leg periwound skin of the wounds and RN #14 was not observed to have placed Zinc around any of the left leg wounds.</p> <p>During an interview on 3/17/14 at 4:44 P.M., RN #14 indicated she should not have put her hands in her scrub jacket pockets with dirty gloves on to look for her scissors or the NS vials. She indicated she should have removed one leg dressing at a time and redressed that leg before she started the other leg. She indicated she should have washed her hands when she reentered the room after she reviewed the resident's treatment orders on the computer before she began dressing the resident's legs. She indicated she should have had all her dressing supplies ready before she took the dressings off and left the wounds uncovered for that length of time making the areas susceptible to infection.</p>						

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	<p>The resident's record was reviewed on 3/14/14 at 3:05 P.M. Diagnoses included, but were not limited to, pressure ulcer of the ankle, cellulitis and abscess of the foot except toes, PVD (peripheral vascular disease), BLE (bilateral lower extremity) wounds, and edema.</p> <p>The resident's March 2014 Medication Administration Record Physician orders included, but were not limited to the following: 1/22/14-Skin Prep Wipes Apply skin prep to bilateral heels every shift. 2/10/14-Wound #1 Right Lateral Dorsal Foot-Heel Foam to right heel. Wrap with roll gauze and ace wrap Calcium Alginate to Dorsal Foot. Cover with dry and Roll gauze wrap with ace wrap to toes and to below knee. 2/10/14-Wound #2 Right Heel-Prisma dry daily to right foot wound. Cover with dry roll gauze. Secure with tape. If prisma dry at dressing change. May moisten with saline or sterile water. Heel foam to right heel wrap with roll gauze and ace wrap. Apply Santyl to wound cover dry abdominal roll gauze Secure with surgical tape. 2/12/14-Cleanse open area to right anterior lower leg with normal saline, pat dry, apply santyl, cover with Normal saline moistened gauze and secure with bordered gauze. Change daily and prn for soilage and dislodgement. 2/22/14-Left leg open area mid lower extremity. Apply santyl to wound cover dry abdominal roll gauze. Secure with surgical tape. 2/28/14-Prisma dry daily to right foot wound. Then cover with dry roll gauze. Secure with tape. If prisma is dry at dressing change, moisten with saline.</p>			

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F000323 SS=D	<p>2/28/14-Zinc (provides a protective barrier to the skin around a wound) to left leg periwound skin. 3/14/14-Skin prep to right heel daily.</p> <p>A current policy titled "Dressing Change, Clean" dated 2006 provided on 3/17/14 at 3:30 P.M. by Nursing Consultant #3, indicated "...Purpose: To protect wound...To prevent infection and spread of infection, To promote healing... Procedure:...Create clean field with paper towels or towelette drape...Put on first pair of disposable gloves...Put on second pair of disposable gloves...Apply prescribed medication...."</p> <p>3.1-40(2) 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.</p> <p>Based on observation, interview and record review, the facility failed to adequately monitor a resident with a history of falls. This deficient practice affected 1 of 1 resident reviewed for accidents. (Resident B).</p> <p>Findings include:</p> <p>During an interview on 3/10/2014 at 3:08 P.M., LPN #1 indicated Resident B had sustained a fall on 2/28/2014.</p> <p>On 3/13/2014 at 2:22 P.M., Resident B's record was reviewed. Diagnoses included, but were not limited to, osteoarthritis shoulder region, anemia in chronic kidney disease,</p>	F000323	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B has had no additional falls since the alleged deficient practice.</p> <p>How will other residents having</p>	

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	<p>hypothyroidism, hypertension and diabetes.</p> <p>The Fall risk care plan, dated 1/9/14, indicated medical factors to include unsteady gait, poor safety awareness, weakness, and history of falls. Interventions were to provide adequate lighting, observe for side effects of meds, keep call light within reach, encourage use of call light, provide verbal safety cues, and provide/reinforce use of non-skid foot wear. Other interventions: 1 person hands-on assistance and place w/c (wheel chair) away from bed.</p> <p>An IDT (Inter-Disciplinary Team) post-occurrence assessment and plan review, dated 3/3/14, indicated the resident had a history of falls, and on 2/28/14," the resident self ambulated to restroom, lost balance in bathroom, fell denies hitting head and pain. No apparent injury this time." The targeted plan to prevent recurrence was the use of non-skid footwear provided while in bed.</p> <p>On 3/17/2014 at 11:00 A.M., Resident B's left knee and below knee area was observed with a discoloration on it. At this time LPN #2 indicated that it must have happened when the resident was transferring recently.</p> <p>On 3/18/2014 at 2:30 P.M., record review indicated there was a fall report on this resident dated 3/14/14 at 11:15 A.M. The report indicated the resident was attempting to get in a wheel chair from the bed but was caught by housekeeping staff who assisted the resident to the floor. One set of vital signs were recorded but the report was not signed nor was there any indication of a follow up in any way.</p>		<p>the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents who may experience a fall may be at risk for the alleged deficient practice. In order to avoid this, nursing staff have been re-educated regarding the fall management policy.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Nursing staff have been re-educated regarding the fall management policy. New falls will be reviewed in the clinical management meetings to ensure appropriate interventions are in place, monitoring has been initiated and care planning is complete.</p> <p>A "Fall Tracking" audit will be completed to ensure monitoring and documentation was completed.</p>	

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F000329 SS=E	<p>The facility's Fall Management Policy and Procedure dated October 2010 indicated, "... procedure for responding to a fall: observe condition for a minimum of 72 hours. Document pertinent details and notifications. Review, revise, and update care plan accordingly"</p> <p>In an interview on 3/18/2014 at 2:30 P.M., Consultant #4, indicated there were no other vital signs or other follow up information on this resident's fall. She indicated there was no follow up for this fall.</p> <p>3.1-45(a)(2) 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>	F000329	<p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The "Fall Tracking" audit will be reviewed by nursing management at least 3 times per week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	
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	<p>Based on interview and record review the facility failed to monitor laboratory values for a diuretic medication for 1 of 5 residents reviewed for monitoring lab values, failed to ensure non-pharmacological interventions for anti-anxiety medications were in place and clarification for use of the anti-anxiety medications were available for 2 of 5 residents reviewed for anti-anxiety medications, and failed to ensure a diagnosis and indicators for use of an antipsychotic medication was present for 1 of 5 residents reviewed for use of antipsychotic medications. (Residents #67, #16, B, and #78)</p> <p>Findings include:</p> <p>1. Resident #67's record was reviewed on 3/14/14 at 3:00 P.M. Diagnoses included, but were not limited to, diabetes type II, congestive heart failure and ischemia heart disease.</p> <p>The March 2014, Medication Administration Record included, but were not limited to the following orders: 06/21/13-Furosemide (diuretic medication) 40 mg by mouth twice daily. 06/21/13-Metolazone (diuretic medication) 5 mg Give on Monday and Friday by mouth.</p> <p>The resident had a Basic Metabolic Panel drawn on 6/28/13 which indicated the following labs were abnormal: BUN-31 (H) 7-19 Normal Glucose-241 (H) 64-112 Normal</p> <p>The resident's record indicated Pharmacy reviews were completed on the following dates with no documentation of laboratory test recommendations:</p>		<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 67, Resident 16, Resident B and Resident 78 have had their medication regimens reviewed by the practitioner. Regimens were modified and/or modifications were made in order to ensure supporting diagnoses were provided.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents receiving diuretics or psychotropic medications are at risk for the alleged deficient practice.</p> <p>An audit of residents receiving diuretics was completed to ensure appropriate lab monitoring is in place. An audit of residents receiving psychotropic medications was completed to ensure supporting diagnoses were provided and monitoring is in place.</p>	

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	<p>6/27/13 7/18/13 8/28/13 9/23/13 10/25/13 11/19/13 112/23/13 1/30/14 2/27/14</p> <p>During an interview on 3/18/14 at 4:40 P.M., Consultant #4 indicated that the laboratory orders to be ordered by the Physician would depend on what the Physician preferred to be ordered, but she would expect a metabolic panel to be ordered at least every 3-6 months.</p> <p>2. Resident #16's record was reviewed on 3/14/14 at 1:28 P.M. Diagnoses include, but were not limited to, history of fall, fatigue, generalized anxiety disorder, hypertension, esophageal reflux, history of urinary tract infection, and esophageal reflux.</p> <p>The resident's March medications included, but were not limited to, Alprazolam (anxiolytic) 0.5 mg (milligrams) by mouth as needed every 12 hours, Temazepam (hypnotic) 30 mg by mouth once daily at bedtime.</p> <p>The record indicated the resident was being administered Alprazolam 0.5 mg every 12 hours but it lacked documentation on the reason this as needed medication was being given for.</p> <p>The resident's MAR (Medication</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>New orders for diuretics will be reviewed during clinical management meetings and a "Diuretic Tracking" audit will be utilized to ensure appropriate lab monitoring is in place.</p> <p>New orders for residents receiving psychotropic medications will be reviewed during clinical management meetings and a "Psychotropic/ Behavior Monitoring" audit will be utilized to ensure behavior monitoring and supporting diagnoses are in place.</p> <p>Staff have been re-educated regarding the "STOP and Watch" Tool for communicating resident behaviors to nursing staff. Nursing staff will assess the resident, pursue appropriate interventions and document accordingly.</p>	

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	<p>Administration Record) indicated, "for those residents on antianxiety psychoactive medications, please identify targeted behaviors to be monitored: <input type="checkbox"/> Anxious or Nervous Symptoms/Complaints <input type="checkbox"/> Worried Facial Expressions <input type="checkbox"/> Hyperventilations; SOB; Dyspnea Protocol: Document Behavior in comments field using numeric scale. If no behavior, document 0 in comments field."</p> <p>The MAR indicated the resident received Alprazolam 0.5 mg on : 3/4/14 at 9:03 A.M., the monitoring column was blank giving no explanation on why the resident received the medication. 3/5/14 at 3:21 A.M., the monitoring column was blank with no explanation on need. 3/6/14 at 2:41 A.M., the monitoring column was blank with no explanation on need. 3/10/14 at 2:11 A.M., the monitoring column was blank with no explanation on why the medication was given. 3/13/14 at 11:54 A.M., the monitoring column was blank with no explanation on why the as needed medication was needed by the resident.</p> <p>The record indicated the resident has been ordered Temazepam 30 mg by mouth once daily at bedtime but again lacked documentation on the reason why and clear monitoring of the medication.</p> <p>The resident's MAR (Medication Administration Record) indicated for Temazepam, "for those residents on Hypnotic / Sedative psychoactive medications, please identify targeted</p>		<p>Nursing staff have been re-educated regarding diagnoses for psychotropic medication, behavior monitoring, and lab monitoring for residents receiving diuretics.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The "Diuretic Tracking" and "Psychotropic/ Behavior Monitoring" audits will be reviewed by the clinical management team at least 3 times per week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>behaviors to be monitored: <input type="checkbox"/> Has trouble falling asleep <input type="checkbox"/> Has trouble staying asleep <input type="checkbox"/> Complaints of insomnia Protocol: Document Behavior in Comments field using numeric scale If no behavior, document 0 in comments field."</p> <p>The record indicated that the order for Temazepam 30 mg was being checked daily but no monitoring was being recorded.</p> <p>In an interview on 3/21/14 at 11:50 A.M., Consultant #4 indicated no other documentation on medication administration and monitoring was available.</p> <p>3. Resident B's record was reviewed on 3/18/2014 at 10:00 A.M. Diagnoses included, but were not limited to, osteoarthritis shoulder region, anemia in chronic kidney disease, hypothyroidism, hypertension and diabetes.</p> <p>The resident's March medications included, but were not limited to, Alprazolam 0.25 mg tablet by mouth daily at bedtime, Mirtazapine (anti-depressant) 7.5 mg tablet by mouth at bedtime.</p> <p>The record indicated the resident was being administered Alprazolam (antianxiety medication) 0.25 mg tablet by mouth at bedtime.</p> <p>The resident's MAR (Medication Administration Record) indicated, "for those residents on antianxiety psychoactive medications, please identify targeted behaviors to be monitored: <input type="checkbox"/> Restlessness / Fidgeting <input type="checkbox"/> Wandering or Pacing</p>			

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	<p><input type="checkbox"/> Anxious or Nervous Symptoms/Complaints</p> <p><input type="checkbox"/> Worried Facial Expressions</p> <p><input type="checkbox"/> Repetitive verbalizations / questions</p> <p><input type="checkbox"/> Hyperventilations; SOB; Dyspnea</p> <p>Protocol: Document Behavior in comments field using numeric scale. If no behavior, document 0 in comments field."</p> <p>The record lacked documentation that any of the monitoring for the anti-anxiety medication was being done.</p> <p>No guide lines for the anti-depressant the resident was receiving were found. No behavior monitoring for the anti-depressant were found in the resident's record.</p> <p>In an interview on 3/21/14 at 11:50 A.M., Consultant #4 indicated no other documentation on medication administration and monitoring was available.</p> <p>4. The record for Resident # 78 was reviewed on 3/14/14 at 12:00 P.M. Diagnoses included, but were not limited to, stroke, seizures, high blood pressure, diabetes, and dementia.</p> <p>The nurses notes indicated the resident had experienced some episodes of yelling out in September, 2013, but there had been no</p>			

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	<p>other concerns following a readmission to the facility on 12/31/13.</p> <p>The March, 2014 physician's orders included the following: Risperidone (Risperdal--an antipsychotic medication) 0.5 mg. (milligrams)-- give 2 tablets by mouth twice daily (ordered at readmission on 12/31/13)</p> <p>A specific diagnosis for the use of the Risperdal was not found.</p> <p>The behavior monitoring listed general behavior categories of: Substantial difficulty with ADL's; Verbally aggressive toward others; Continuous yelling; and Resists medications.</p> <p>The residents documentation indicated the resident had displayed none of these behavior categories December 2013 thru March 16, 2014. The "Comment" section indicated "0", meaning no behaviors for all categories.</p> <p>A Consultant Psychiatrist progress note, dated 1/12/14, indicated: "Since patient's last visit with this provider, the family attempted to take the patient home to care for her and the resident was taken to the emergency room and readmitted." The notes indicated the resident was compliant with medications, and no sleep or appetite issues were noted. The Consultant Psychiatrist listed a diagnosis of dementia with psychosis; however there was no other information describing how the psychosis was displayed or how the diagnosis was determined.</p> <p>There was no documentation found in Social Service, Nursing, or Physician progress</p>			

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F000353 SS=E	<p>notes that discussed the reasons for starting Risperidone in December, 2013.</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review the facility failed to have enough staff available for 10 of 10 residents reviewed for sufficient nursing staff causing significant discomfort including incontinent episodes for 5 of the 10 residents. This deficient practice has the potential to affect all 69 of the residents currently residing in the facility. (Residents B, C, E, F, G, H, #16, #20, #68, #74).</p>	F000353	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Nursing staff has been re-educated regarding timely response to resident needs to prevent recurrence of the</p>	

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	<p>Findings include:</p> <p>1. Resident B on 3/12/14 at 9:36 A.M., during an interview, indicated there is not enough staff and many times she has had to wait for help.</p> <p>Resident B's record was reviewed on 3/18/2014 at 10:00 A.M. Diagnoses included, but were not limited to, osteoarthritis shoulder region, anemia in chronic kidney disease, hypothyroidism, hypertension and diabetes.</p> <p>A "Change of Condition" SBAR [Situation, Background, Assessment, Response], dated 3/16/2014 at 10:00 P.M. indicated Resident B was verbally responsive though not able to effectively communicate as usual. "Unable to form complete words... MD response: New orders: CBC [Complete Blood Count]; BMP [Basic Metabolic Panel]; UA C&S [Urinalysis Culture and Sensitivity]."</p> <p>A late entry made on 3/18/14 at 12:20 P.M., for 3/17/14 at 6 P.M., indicated the resident's family requested she be sent out as she was "not herself." Vital signs taken at that time indicated the following: "BP[blood pressure] 130/70, P[pulse] 95, R[respirations] 19, Sat [oxygen saturation] 87 percent, T [temperature] 100.9 Fahrenheit."</p> <p>During an interview with Nurse Consultant #3 on 3/18/14 at 3:40 p.m., she indicated the Urinalysis had not been completed due to "they didn't have time." The Urinalysis was ordered on 3/16/14 at 10 p.m., and the resident was not sent to the hospital until the evening of 3/17/14.</p> <p>2. Resident C on 3/12/14 at 1:54 P.M., during an interview, indicated he has had to wait soiled a long time and has missed</p>		<p>alleged deficient practice. These allegations were taken by resident report rather than observations documented in this report.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents requiring assistance with incontinence care are at risk for the alleged deficient practice. Additional nurse management supervision has been added for the second and third floors to monitor for timely provision of care and make staffing adjustments as indicated.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Administration has reviewed staffing patterns and implemented adjustments to increase availability</p>	

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	<p>receiving therapy as a result.</p> <p>On 3/21/2014 at 10:30 A.M., Consultant #4 indicated the resident had behaviors towards staff which made for a difficult situation.</p> <p>Resident C's record was reviewed on 3/21/2014 at 11:00 A.M. Diagnoses included, but were not limited to a history of a stroke in 2002 affecting his left side, respiratory complications, generalized pain, constipation, chronic airway obstruction, history of an old heart attack, hypothyroidism, asthma, depressive disorder, esophageal reflux, diabetes, mood disorder and anxiety disorder.</p> <p>An initial Social Service assessment, dated 2/11/14; indicated the resident was originally admitted from the hospital on 12/30/13 and returned to the hospital on 1/28/14. He returned back to the facility on 2/4/14. The assessment indicated "Resident is a long term placement and full code. He continues to be alert and oriented to all spheres, able to use the call-light to make his needs known. He can be very polite friendly and cooperative but at the drop of a dime he can change his personality. Today he has been verbally abusive to female staff of color [staff who provide direct care]. To writer who is a person of color he has been respectful. [Resident's name] puts on his call-light and then when staff comes, he says he wants some one else." The Social Service assessment continued explaining that the resident called a family member and stated staff was not answering his call light and that he was having difficulty breathing. The family member called the facility concerned. The SSD(Social Service Director) went and observed the resident and checked</p>		<p>of CNAs, nurses and social services.</p> <p>Quality Assurance Rounds were initiated for management staff to observe residents' general condition and field care concerns potentially related to staffing.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The Quality Assurance Rounds will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>periodically throughout the rest of the afternoon and noted that the resident was frequently placing call-light on and that staff was answering it.</p> <p>A "Social Service Assessment," dated 2/18/14, indicated under additional comments:"... States he did not know why he did things but thought it was because he was missing his mother. Writer counicled on grief and loss issues and how the sense of loss will always be with him but lashing out at others has not made him feel better and it never will. Writer discussed coping options of during times of what seems to be an overwhelming sense of grief, he should focus on the good times and the blessings he had in having a positive role model in his mother. Resident was more at peace. When writer exited he ask if writer would come and talk to him again. Behaviors ceased for the rest of the afternoon."</p> <p>No follow up was located in the resident's record. During an interview on 3/21/14 at 11:21 A.M., the SSD (Social Service Director) indicated she had not been able to follow up on Resident C because her work load was significant. She indicated there use to be 2 staff in Social Service Department for the facility, but now there was just one and she was doing the best she could.</p> <p>3. Resident E on 3/11/14 at 11:13 A.M., during an interview, indicated she goes to the bathroom by herself because if she waited on the staff to answer her light she would be wet all the time. She is not suppose to be unassisted but she doesn't like to be wet. She indicated evenings was the worst.</p> <p>4. Resident F on 3/12/14 at 11: 28 A.M.,</p>			

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	<p>during an interview, indicated night time they are short many times and in the morning he is drenched and the daytime nursing assistant has to change everything on his bed.</p> <p>5. Resident G on 3/10/14 at 3:36 P.M., during an interview, indicated there is not enough staff to make sure you get the care and assistance you need without having to wait a long time. A wait of at least 30 minutes is common.</p> <p>6. Resident H on 3/11/14 at 10:53 A.M., during an interview, indicated there is not enough staff and everyone has to wait at least 30 minutes to get help.</p> <p>7. Resident #16 on 3/11/14 at 9:49 A.M., during an interview, indicated she sees a lot of over worked nursing assistants and sometimes she has to wait on her medications in the evening.</p> <p>8. Resident #20 on 3/11/14 at 9:47 A.M., during an interview, indicated she has had to wait an average of an hour to get help.</p> <p>9. Resident #68 on 3/12/14 at 3:15 A.M., during an interview, indicated there is not enough staff on the weekend. She has had to wait over an hour for her light to be answered and had a urine incontinent episode as a result.</p> <p>10. Resident # 74 on 3/11/14 at 1:41 P.M., during an interview, indicated he waited 45 minutes for his light to be answered after a bowel incontinent episode. He has some excoriation as a result. Resident #74's record review indicated he has had to receive treatment to his bottom with medication to</p>			

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F000441 SS=D	<p>help heal a skin irritation.</p> <p>11. During an interview on 3/18/14, with a staff member that wished to remain unanimous, indicated there is not enough staff.</p> <p>This Federal tag relates to Complaint IN00144974.</p> <p>3.1-17(a) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable 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.</p>			

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	<p>(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 sanitize a glucometer appropriately for 1 of 2 residents, failed to perform appropriate handwashing for 1 of 1 residents during a dressing change and while warming up breakfast, and failed to ensure infection control guidelines were followed during a dressing change for 1 of 1 residents reviewed for dressing changes. (Residents #15 and B)</p> <p>Findings include:</p> <p>1. On 3/14/14 at 12:02 P.M., LPN #8 was observed checking Resident #15's blood sugar. After LPN #8 washed her hands, she placed a Sani wipe and an alcohol wipe box with strips and lancets on top of her medication cart without a barrier. She placed the glucometer on top of the Sani wipe package. She placed a clean paper towel on top of the cart and donned clean gloves. She placed the glucometer on top of the paper towel. She sanitized the glucometer with the Sani-wipe for 10 seconds and placed it back on the same paper towel, which was on the medication cart. She sanitized her hands with alcohol gel. She placed the glucometer in the alcohol box on top of the other supplies in the box.</p>	F000441	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Nursing staff has been re-educated regarding infection control in order to prevent recurrence of the alleged deficient practice.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>All residents requiring blood sugar monitoring and clean dressing changes are at risk for the alleged deficient practice.</p>	04/20/2014

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	<p>After entering the resident's room, she placed the alcohol box on the end of the resident's bed and donned clean gloves. She prepared the glucometer and placed it back in the alcohol box while she cleansed the resident's finger. After the blood sample was drawn, LPN #8 placed the glucometer back in the alcohol box with used lancet and alcohol swabs. She washed her hands. She returned to her cart and placed the used glucometer on a clean paper towel on the top of the medication cart. She donned clean gloves and sanitized the glucometer for 15 seconds, then placed it back on the same paper towel on the medication cart. She sanitized her hands with alcohol gel.</p> <p>During an interview on 3/14/14 at 12:18 P.M., LPN #8 indicated she should have placed her supplies on a barrier on the medication cart and in the resident's room. She indicated she was unsure of the length of time the glucometer was to be sanitized. After she read the back of the "Sani-Wipe" cloth directions, she indicated she should have sanitized the glucometer for 2 minutes and kept it wet during this entire time, then let it air dry. She indicated she should not have placed the glucometer back in the alcohol swab box after she checked the resident's blood sugar due to potential cross-contamination. The supplies in the alcohol box was considered to be clean. She indicated she had contaminated her glucometer after she sanitized it when she placed it back on the same paper towel she had on her medication cart.</p> <p>A current policy titled "Glucose Meter, Cleaning/Disinfecting," dated 2010, indicated; "...Purpose: To clean/disinfect glucose monitoring devices when used between</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</p> <p>Nursing staff has been re-educated and completed skills validations regarding proper disinfecting of glucometers, handwashing and clean dressing change procedures.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>Glucometer use observations will be completed by nursing management at least 5 times per week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p> <p>Handwashing observations will be completed by nursing management at least 5 times per week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>multiple residents...Procedure: 1. Clean/Disinfect the exterior of glucose meter and strip housing after each use and when visibly soiled with blood or bloody fluids. 2. Utilize an EPA registered hospital trade disinfectant approved by units manufacturer...6. When using a disposable professional trade wipe, follow package instructions for use to ensure the device/surface is [wet covered] for the proper length of time go kill pathogens."</p> <p>2. On 3/11/14 at 10:45 A.M., Resident B was observed sitting in her wheel chair eating her breakfast. The resident's bare right foot was resting on the bare floor. A nickel to quarter patch of skin on the top of her foot had been torn and was exposed to air. There was a red smear on the floor near her foot. The ADON (Assistant Director of Nursing) came into the resident's room wearing some gloves and carrying some gauze. She bent down next to the resident and indicated she was applying pressure to the top of the resident's foot. She indicated the skin on the top of the foot had been torn after an old dressing was removed.</p> <p>The ADON blotted the top of the resident's foot. After finishing she went into the bathroom and threw the gloves and gauze away in an almost overflowing trash can. She put on another pair of gloves in the bathroom and failed to wash her hands before grabbing the gloves. She placed a Band-Aid on the wound and applied an ace type wrap around the foot.</p> <p>The ADON then went into the bathroom and</p>		<p>Dressing change observations will be completed by nursing management at least 3 times per week for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>removed the gloves she had been wearing. She proceeded to wash her hands for 8 seconds, dried them quickly and then left the room with the resident's cereal she was warming up.</p> <p>On 3/14/14 at 2:50 P.M., the DON (Director of Nursing) provided the facility's policy and procedure for dressing change. The policy and procedure titled "Dressing Change, Clean" and dated 2006, indicated the following:</p> <p>"Purpose : to protect wound, to prevent irritation, to prevent infection and spread of infection, to promote healing"</p> <p>"Procedure : 1. Place plastic bag near foot of bed to receive soiled dressing. 2. Create clean field with paper towels or towelette drape. 3. Remove old adhesive with adhesive remover, if necessary, taking care not to get solution into wound. 4. Open dressing pack. 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Put on second pair of disposable gloves. 9. Pour prescribed solution onto gauze to be used for cleaning, if required. 10. Cleanse wound with prescribed solution. 11. Apply prescribed medication if ordered. 12. Apply dressing and secure with tape. 13. Remove gloves and discard with all unused supplies in plastic bag. 14. Assist resident in comfortable position with call light in reach."</p> <p>The CDC (Centers for Disease Control and prevention) recommends: "Scrub your hands for at least 20 seconds. Hum the "Happy Birthday" song from beginning to end twice." http://www.cdc.gov/features/handwashing.</p>			

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F000465 SS=D	<p>3.1-18(l) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain resident rooms in a sanitary manner. (Rooms #308, 324, 326, and 336)</p> <p>Findings include:</p> <p>1. On 3/10/14 at 3:19 P.M., the privacy curtain between the two resident beds in Room #336 was observed to have a brown residue on it. A "Kangaroo" brand feeding pump pole was observed to have a dried, golden yellow-colored substance down the pole, and on all four of the legs at the bottom of the pole. On 3/11/14 at 9:45 A.M., the same dried, yellow substance was observed on the pump stand. On 3/12/14 at 1:25 P.M., the feeding pump pole was observed to have the same dried residue down the pump, on the pole, and on four legs at the bottom of the pole.</p> <p>During an interview on 3/14/14 at 11:58 A.M., LPN #7 indicated the dried golden brown residue on the feeding pump, pole and legs of the pole in Room #336 was probably feeding that was wasted priming the tubing when hanging the feeding. She indicated the privacy curtain brown and red residue may be food or juice.</p> <p>2. On 3/10/14 3:40 P.M., 1 bedpan and 2 wash basins were observed in the bathtub in</p>	F000465	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Rooms 308, 324, 326, and 336 have been substantially cleaned and the observed items were addressed.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be affected by this alleged deficient practice. All rooms were audited for potential concerns related to this alleged deficient practice and appropriate plans to address issues were initiated. What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? Quality Assurance Rounds were initiated for management staff to observe and communicate concerns about the environmental conditions of resident rooms. Appropriate action will be taken relevant to these observations. Maintenance and Housekeeping</p>	

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	<p>the bathroom of Room #326. The wash basins were placed on top of the bedpan- -none were wrapped in plastic bags, to indicate they were "clean." On 3/11/14 at 10:00 A.M., the bedpan and wash basins were observed still in the bathtub. On 3/12/14 at 10:29 A.M., the bedpan and wash basins were observed still in the bathtub in the bathroom without bags around them.</p> <p>3. On 3/10/14 at 3:42 P.M., 1 bedpan and 2 wash basins were observed in the bathtub in the bathroom of Room #324. The wash basins were placed on top of the bedpan- -none were wrapped in plastic bags, to indicate they were "clean." A "Kangaroo" brand feeding pump was observed to have a dried, golden brown-colored substance running down the front of the pump. The pole and the four legs at the bottom of the pole were observed to have a dried, golden-brown substance on them.</p> <p>On 3/11/14 at 10:30 A.M., the same dried, golden-brown substance was observed on the feeding pump and stand. On 3/11/14 at 2:16 P.M., the bedpan and a wash basin were observed in the bathtub without bags on them.</p> <p>On 3/11/14 at 2:40 P.M., the floor around the Kangaroo feeding pump had a large puddle of dried golden brown liquid. A Housekeeping staff person was soaking the substance in order to clean it up. In an interview at that time, she said "Those things leak all over the floor, all the time."</p> <p>During an interview on 3/14/14 at 1:10 P.M., LPN # 5 indicated the dried golden brown residue on the feeding pump, pole and legs of the pole in Room #324 was old feeding</p>		<p>staff will be re-educated regarding communicating concerns about environmental conditions to their supervisors so that prompt and appropriate actions are taken.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Quality Assurance Rounds will be reviewed at least three times a week for four weeks, then weekly thereafter unless identified as requiring adjustment through the QA process.</p>	

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	<p>and she would clean it off.</p> <p>On 3/12/14 at 10:45 A.M., feeding pump was observed to have the dried substance down the front of the pump, the pole, and the four legs at the bottom of the pole.</p> <p>4. On 3/11/14 at 1:57 P.M., a pink wash basin with a bedpan placed inside of it was observed in the bathtub in bathroom of Room #308. None were wrapped with plastic bags to indicate they were "clean."</p> <p>During an interview on 3/14/14 at 11:25 A.M., Nurse Consultant #3 indicated the wash basins and the bedpans should be placed in plastic bags for sanitary purposes.</p> <p>3.1-.19(f)</p>			