

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/20/2014
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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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F000000	<p>This visit was for the recertification and State Licensure Survey.</p> <p>Survey dates: February 12, 13, 14, 17, 18, 19, 20, 2014</p> <p>Facility number: 000315 Provider number: 155720 AIM number: 100289030</p> <p>Survey Team: Dorothy Watts, RN, TC Terri Walters, RN Amy Wininger, RN</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payer type: Medicare: 2 Medicaid: 36 Other: 6 Total: 44</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC16.2</p> <p>Quality review completed on February 24, 2014 by Jodi Meyer, RN</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective March 15, 2014 to the state findings of the annual survey conducted on February 12, 13, 14, 17, 18, 19 and 20, 2014.</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=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician was notified of a change in a resident's condition, in that, the physician was not</p>	F000157	The corrective action taken for those residents found to have been affected by the deficient practice is that the clinical record of the resident identified as resident #29 has been reviewed.	03/15/2014

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	<p>notified of the onset of confusion and/or discomfort for 1 of 3 residents with an indwelling catheter (Resident #30) and failed to notify the physician and family of a deterioration in the condition of a resident's pressure area for 1 of 4 residents reviewed for pressure ulcers. (Resident #29)</p> <p>Findings include:</p> <p>1. On 02/17/14 at 8:30 A.M., Resident #30 was observed lying in bed with closed eyes. At that time, a catheter drainage bag was observed hanging on the bed frame.</p> <p>The clinical record of Resident #30 was reviewed on 02/17/14 at 12:00 P.M. The record indicated the diagnoses of Resident #30 included, but were not limited to, dementia, anxiety, and urinary retention.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 11/22/13 indicated Resident #30 experienced moderate cognitive impairment. The MDS further indicated, Resident #30 received anti-anxiety medications routinely during the assessment period.</p> <p>A Physician's Telephone Order</p>		<p>The physician and the resident's responsible party have been updated on the resident's current condition and plan of care. The nurses responsible for the identified documentation have received one on one education on facility practice of physician and family notification. The corrective action taken for those residents having the potential to be affected by the same deficient practice is that a house wide review of each resident's nurses notes has been completed. No other residents were identified to have been affected by this deficient practice. The measures that have been put into place to ensure the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the acceptable standards of practice as it relates to physician and responsible party notification of any change in the resident's condition and plan of care. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor changes in condition of residents to ensure physician and responsible party notification has been completed in accordance with acceptable standards of practice. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters.</p>		

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	<p>dated 02/04/14 indicated an order was received to anchor an indwelling catheter for urinary retention.</p> <p>A Care Plan dated 02/04/14 indicated a problem of, "requires indwelling f/c (catheter) r/t (related to) urinary retention" with interventions that included, but were not limited to, "1. observe for ...confusion, c/o (complaint of) abd (abdominal) ...pain...2. keep MD (Medical Doctor) informed of any changes..."</p> <p>A nurse's note dated 02/07/14 at 2200 (10:00 P.M.) indicated, "Res (Resident) increased confusion this evening. Trying to stand up unassisted several times stating 'I have to p**(urinate).' When reminded ... has a catheter "I have to p***." Sat on bedside commode, no results." The note lacked any documentation the physician had been notified of Resident #30's confusion and/or abdominal discomfort.</p> <p>A nurse's note dated 02/08/14 at 0430 (4:30 A.M.) indicated, "Res continues to both use call light at times et (and) at times attempts to get up out of bed unassisted. States she is pregnant et needs to get up</p>		The results of the tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.				

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	<p>CNA assisted res to w/c (wheelchair) et res is sitting in first floor lobby at this time. Immediately c/o wanting to go to bed. Asks "Why are you making me sit here? I want to go to bed." The note lacked any documentation the physician had been notified of Resident #30's confusion and/or abdominal discomfort.</p> <p>A nurse's note dated 02/08/14 at 0530 (5:30 A.M.) indicated, "... Res continues to try to stand up unassisted from reclining chair. States "I need to p**." Shown et explained ... has catheter in place. States 'Then I have to s***, I'm going to s*** (Bowel Movement) everywhere.' Toileted no results. (Resident #30) Asks why we have (Resident #30) ... sitting there. Reminded ... has attempted many times et continues to attempt to stand unassisted et that is unsafe ... at this time ... needs 1-2 assist...." The note lacked any documentation the physician had been notified of Resident #30's increasing confusion and/or abdominal discomfort.</p> <p>A nurse's note dated 02/08/14 at 0700 (7:00 A.M.) indicated, "... res yelling out "Hey Hey Hey' Res sitting in reclining chair requesting to</p>						

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	<p>go to bed. Reminded its close to time for breakfast ... needs to wait for breakfast. Res attempts to pull catheter out, encouraged to leave cath (catheter) bag on w/c..." The note lacked any documentation the physician had been notified of Resident #30's continued confusion and/or discomfort.</p> <p>A nurse's note dated 02/08/14 at 0725 (7:25 A.M.) indicated, "...Res sitting in recliner yelling out help help trying to stand up et scooting self to edge of chair. Resident refused drink when offered...staff assist of 2 (two) with transfer to w/c to go in dining room for breakfast..." The note lacked any documentation the physician had been notified of Resident #30's confusion and/or discomfort.</p> <p>A nurse's note dated 02/08/14 at 0800 (8:00 A.M.) indicated, " Res has been toileted prior to breakfast, ate few bites of cereal et then stating, "I need to go, I have to go p**." Explained to res ... has a catheter. Res propelling self away from table in w/c grabbing @ (at) catheter. Staff assisted res to table again et assist with enc (encourage) to eat more breakfast., ate 50% et drank 240 cc (cubic</p>			

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	<p>centimeter)...taken to toilet again et lay down per 2 assist..." The note lacked any documentation the physician had been notified of Resident #30's confusion and/or discomfort.</p> <p>During an interview on 02/19/14 at 3:00 P.M., the DON (Director of Nursing) indicated a specific policy could not be provided, but it was facility practice for the physician to be notified if a resident with an indwelling catheter exhibited signs that included, but were not limited to, confusion and/or abdominal discomfort.</p> <p>2. The clinical record of Resident #29 was reviewed on 2/18/14 at 3:05 P.M. The record indicated the diagnoses of Resident 29 included, but were not limited to, dementia, depression, schizophrenia, Baretis Esophagitis.</p> <p>The Care Plan: "...At Risk For Pressure Ulcers... Interventions...2. Notify Md Of Any Changes...."</p> <p>Page 1. The Pressure Ulcer Condition Monitoring Sheet indicated on 1/16/14 the Stage 2 pressure area to the left buttock measured 0.5 cm by 0.5 cm. The</p>			

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	<p>treatment progress note read: "Xenoderm healing"</p> <p>Page 2. The Pressure Ulcer Condition Monitoring Sheet indicated on 1/23/14 the Stage 2 pressure area to the left buttock measured 1cm by 0.7 cm. The treatment progress note read: "deteriorated"</p> <p>Page 3. The Pressure Ulcer Condition Monitoring Sheet indicated on 1/30/14 the Stage 2 pressure area to the left buttock measured 0.6 cm by 0.4 cm. The treatment progress note read: "improved"</p> <p>Page 4. The Pressure Ulcer Condition Monitoring Sheet indicated on 2/13/14 the Stage 2 pressure area to the left buttock measured 1 cm by 1 cm. The treatment progress note read: "deteriorated"</p> <p>Nursing progress notes dated 1/23/14 were reviewed on 2/18/14 at 3:00 P.M. Documentation was lacking concerning the notification of Resident #29's physician and family in regards to the deterioration of a Stage 2 pressure ulcer.</p>			

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	<p>No Nursing progress notes were recorded for 2/13/14. Documentation was lacking to indicate Resident #29's physician and family had been notified of the pressure area.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 2/18/14 at 3:05 P.M., the ADON indicated that whenever a resident experienced a change in their condition the physician and family should be notified and the notification should be documented in the nurses' notes. The ADON indicated she did not see the notification documented in Resident #29's nurses' notes.</p> <p>The facility's policy and procedure for Physician Notification was provided by the Director of Nursing and reviewed on 2/18/14 at 4:30 P.M. The policy read as follows: "...It is the facility policy that each resident's physician is promptly informed concerning any significant event, change of condition or need of possible treatment for the resident. It is the responsibility of the licensed nurse to keep the physician informed and document in the clinical record each notification of the physician...."</p>				

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	3.1-5(a)(3) 3.1-5(a)(2)			

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F000225 SS=D	<p>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 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>	F000225	The corrective action taken for	03/15/2014			

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	<p>Based on interview and record review, the facility failed to ensure allegations of abuse were immediately reported to the Indiana State Department of Health for 3 of 3 allegations of abuse reports reviewed. (Resident #27, Resident #23, Resident #10)</p> <p>Findings include:</p> <p>1. On 2/12/14 at 12:25 P.M., the Administrator was made aware of allegations of abuse voiced by Resident #27. The Administrator was made aware of the allegation of a male nurse had answered her call light on night shift and "raised Cain" with her. The resident thought he was going to hit her. He took the call bell away. The resident indicated she had reported to the Social Service Director (SSD). The resident indicated the nurse still works here and he's real nice since. Can't remember nurse's name. Happened maybe a month ago. She indicated she thought the SSD had talked to the nurse. Also voiced a problem about her Tylenol medication that was ordered every 4 hours for pain and the nurse had indicated it was every 6 hours for pain. Resident indicated it had happened when the nurse had first</p>		<p>those residents found to have been affected by the deficient practice is that the resident's identified as residents #27, #23 and #10 did not have any negative outcome as a result of not notifying the Indiana State Department of health immediately. The allegations were reported to ISDH within 24 hours. Administration has now been educated on the need to notify ISDH promptly upon identifying any allegation of abuse. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected however there have been on other allegations of abuse reported to the administrator at this time. The measures that have been put into place to ensure the deficient practice does not recur is that the facility has revised their policy and procedure on abuse to include prompt notification of all other officials in accordance with state law (including to the State survey and certification agency). The facility has conducted a mandatory in-service for all staff on the revised policy and procedure. The corrective action taken to monitor to assure compliance is that the facility has implemented the practice that all allegations of abuse will be reviewed at the daily management meeting to ensure</p>	

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	<p>started and happened one time.</p> <p>Also reported to the Administrator on 2/12/14 at 12:25 P.M., that Resident #27 indicated a month or 2 ago in the lobby at TV area the resident was in her chair and would raise her hands to get help from staff at the nurses' station. She indicated staff at nurses' station would not look at her and help. She indicated the staff was young girls who were talking and laughing. She indicated it had happened a lot of times. Doesn't think she told any staff about the incident. She indicated that staff was better now. She indicated she had been indicating to staff she had to go to the bathroom.</p> <p>On 2/17/14 at 3:55 P.M., an incident report sent to the Indiana State Department of Health (ISDH) on 2/12/14 at 5:37 P.M., was reviewed. The report indicated Resident #27 had reported an incident and the incident date was unknown. Resident's diagnoses listed were "Tremors, Hypertension, Idiopathic Hypertrophied subaortic stenosis, Ataxia, type 11 Diabetes, chronic Low Back Pain, Heart Failure, Vascular Disease, Parkinson, Moderate Cataracts, Bi-Polar Disorder with Psychotic Features,</p>		that all components of the revised abuse policy have been completed timely, including the prompt notification of all allegations of abuse to other officials in accordance with state law, including to the State survey and certification agency.		

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	<p><b>Obsessive Compulsive Disorder."</b></p> <p>"Brief description of Incident: During an interview with a state surveyor the resident reported that a male nurse answered her call light and was mean to her. She also reported that he would not give her Tylenol which she said she was suppose to have it every 4 hours. Resident claims she reported this to (Social Service Director's name), Social Service Director..."</p> <p>On 2/17/14 at 3:55 P.M., staff and resident interviews regarding the allegation were reviewed also at that time. Documentation by the SSD dated 2/12/14, indicated she had not been not notified of any complaints or concerns by Resident #27. The only staff documented interviews (on 2/12/14) included in the investigation were from 2 staff working on the unit where Resident #27 resided. These interviews were from CNA #15 and LPN #9.</p> <p>2. On 2/17/14 at 3:55 P.M., an incident report sent to the Indiana State Department of Health (ISDH) on 2/12/14 at 5:43 P.M. was reviewed. The report was in regards to Resident #23. The report indicated:</p>						

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	<p>"...Brief Description of Incident: During an interview with a state surveyor the resident claims that when she is up in lobby she raises her hand to ask for help to use the bathroom and no one helps her. Did not give specific date or time.</p> <p>On 2/18/14 at 10:55 A.M., an incident report with an incident date of 1/1/14 at 6:45 A.M., was sent to the Indiana State Department of Health (ISDH) on 1/2/14 at 10:04 A.M., was reviewed.</p> <p>The report indicated: "...Brief Description of Incident: Resident #23 (resident's name) stood up setting off his chair alarm. CNA #2 was assisting Resident #23 (resident's name) to sit down. Resident #10 (resident's name) struck resident (Resident #23) on the shoulder. Resident #23 (resident's name) struck Resident #10 (resident's name) on the arm.</p> <p>3. On 2/12/14 at 2:00 P.M., the facility's abuse policy entitled "Abuse Policy" (no policy date) was received and reviewed. The policy included but was not limited to: "... If an allegation/suspension of abuse is noted the Administrator will be</p>			

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	<p>notified immediately and the facility abuse procedure will be implemented.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source or 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>On 2/18/14 at 4:15 P.M., the Administrator was interviewed regarding the 3 allegations of abuse reports reviewed. The Administrator was made aware that all 3 allegations had not been reported immediately to the state agency. He indicated he had thought the allegation had to be reported to the state agency within 24 hours of the Administrator notification of the allegation.</p> <p>On 2/18/14 at 4:15 P.M., the Administrator was also made aware a thorough investigation was lacking in regard to the interviewing of staff members regarding the night shift nurse allegation. Two nursing staff</p>			

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F000226 SS=D	<p>(CNA #15 and LPN #9) who had been working on day shift 2/12/14 when the allegation was reported, were the only staff interviewed. The Administrator indicated that CNA #15 and LPN #9 (who had been interviewed) had worked with LPN #10 in the past. The Administrator indicated he would interview more staff on different shifts.</p> <p>3.1-28(c)</p> <p>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 interview and record review, the facility failed to ensure the facility's abuse policy indicated the state agency was notified promptly of an allegation of abuse and/or the policy was incomplete and did cover all required componets for 3 of 3 reported allegations of abuse reviewed.</p>	F000226	The corrective action taken for those residents found to have been affected by the deficient practice is that the residents identified as residents #27, #23 and #10 did not have any negative outcome as a result of not notifying the Indiana State Department of Health immediately. The allegations were reported to ISDH within 24 hours. Administration has now been educated on the need to	03/15/2014			

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	<p>Findings include:</p> <p>The facility's abuse policy entitled "Abuse Policy" (no policy date) was received and reviewed on 2/12/14 at 2:00 P.M. The policy indicated:</p> <p>"Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, family, facility staff, other residents, consultants or volunteers, staff of other agencies servicing the residents and family members or legal guardians, friends, or other individuals.</p> <p>ABUSE: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes residents in a coma.</p> <p>The (sic) are 5 types of abuse: Verbal, Sexual, Physical, Mental and Involuntary seclusion.</p> <p>Prevention includes but not limited to proper screening prior to hire, new employee education, annual and</p>		<p>notify ISDH promptly upon identifying any allegation of abuse. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected however there have been no other allegations of abuse reported to the administrator at this time. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has revised their policy and procedure on abuse to include prompt notification of all other officials in accordance with state law (including to the State survey and certification agency). The facility has conducted a mandatory in-service for all staff on the revised abuse policy and procedure. The corrective action taken to monitor compliance is that the facility has implemented the practice that all allegations of abuse will be reviewed at the daily management meeting to ensure that all components of the revised abuse policy have been completed timely, including the prompt notification of all allegations of abuse to other officials in accordance with state law, including to the State survey and certification agency.</p>		

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	<p>on-going education and family Notification upon admission.</p> <p>If an allegation/suspension of abuse is noted the administrator will be notified immediately and the facility abuse procedure will be implemented.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source or 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>On 2/17/14 at 3:55 P.M., an incident report sent to the Indiana State Department of Health (ISDH) on 2/12/14 at 5:37 P.M. was reviewed.</p> <p>"Brief description of Incident: During an interview with a state surveyor the resident reported that a male nurse answered her call light and was mean to her. She also reported that he would not give her Tylenol which she said she was suppose to have it every 4 hours. Resident claims she reported this to (Social</p>			

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	<p>Service Director's name), Social Service Director..."</p> <p>On 2/17/14 at 3:55 P.M., staff and resident interviews regarding the allegation were reviewed also at that time. Documentation by the SSD dated 2/12/14, indicated she had not been not notified of any complaints or concerns by Resident #27. The only staff documented (2/12/14) interviews included in the investigation were from 2 staff working on the unit where Resident #27 resided. These interviews were from CNA #15 and LPN #9.</p> <p>On 2/17/14 at 3:55 P.M., an incident report sent to the Indiana State Department of Health (ISDH) on 2/12/14 at 5:43 P.M. was reviewed. The report indicated:</p> <p>"...Brief Description of Incident: During an interview with a state surveyor by the resident claims that when she is up in lobby she raises her hand to ask for help to use the bathroom and no one helps her. Did not give specific date or time.</p> <p>On 2/18/14 at 10:55 A.M., an incident report with an incident date of 1/1/14 at 6:45 A.M., was sent to the Indiana State Department of</p>				

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	<p>Health (ISDH) on 1/2/14 at 10:04 A.M., was reviewed.</p> <p>The report indicated: "...Brief Description of Incident: Resident # 23 (resident's name) stood up setting off his chair alarm. CNA #2 was assisting Resident #23 (resident's name) to sit down. Resident #10 (resident's name) struck resident (Resident # 23) on the shoulder. Resident #23 (resident's name) struck Resident #10 (resident's name) on the arm..."</p> <p>On 2/18/14 at 4:15 P.M., the administrator was interviewed regarding the 3 allegations of abuse reports reviewed. The administrator was made aware that all 3 allegations had not been reported immediately to the state agency. He was also made aware the facility's abuse policy did not include the time period required for the state agency notification. The administrator indicated the facility's abuse policy had been redone (no date given). He indicated the previous policy had included conflicting information after updates had been added to the policy. He indicated the facility developed the current policy to simplify for employee use.</p>			

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F000282 SS=E	<p>On 2/18/14 at 4:15 P.M., the administrator was also made aware the facility's abuse policy lacked procedures to ensure a thorough investigation of allegations. Procedures were lacking in regard to the screening, training, prevention, identification, investigation, protecting and reporting to ensure a thorough investigation of allegations. The administrator indicated the facility had simplified the new abuse policy to help employees to understand and utilize.</p> <p>3.1-28(a)</p> <p>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 observation, interview,</p>	F000282	The corrective action taken for those residents found to have	03/15/2014			

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	<p>and record review the facility failed to ensure care was provided according to the care plan, in that, an alternating air mattress was not used according to manufacturer's instruction for 1 of 3 residents who met the criteria for review of pressure ulcers (Resident #13), a breathing treatment was not administered within the time frame identified by the physician's plan of care for 1 of 11 residents reviewed during medication administration. (Resident #57), and residents were not transferred and/or ambulated according to the plan of care for 1 of 2 residents reviewed for transfers and 2 of 2 residents who met the criteria for review of falls. (Resident #29, Resident #37, Resident #56).</p> <p>Findings include:</p> <p>1. Resident #13's clinical record was reviewed on 2/13/14 at 3:30 P.M. His clinical record indicated he had been admitted to the facility in 12/1/76. Diagnoses included but not were not limited to, cerebral palsy with left hemiplegia, seizure disorder, mental retardation, and peripheral vascular disease. A Braden skin scale assessment completed on 2/4/14, indicated a</p>		<p>been affected by the deficient practice is that the alternating air mattress utilized for the resident identified as resident #13 has its controls set in accordance with the manufacturer's guidelines. The manufacturer recommended settings have now been included in the physician's orders for the air mattress and are being checked by the nurses each shift to ensure compliance. The nurses are documenting this validation on the resident's treatment record. The air mattress control settings have also been included on the resident's care plan. The corrective action taken for those residents found to have been affected by the deficient practice is that the physician of resident #57 has been contacted and a clarification order has been obtained. Resident #57 is now receiving breathing treatments within the time frame established by the physician's plan of care. The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #29 has been reviewed to determine her current needs as it relates to transfers. The resident still requires the assist of two staff members for transfers. The CNA identified as CNA #2 has received one on one education on the importance of checking daily each resident's closet worksheet to</p>				

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	<p>total score of 15. A total score of 12 or less represented a high risk for pressure sores.</p> <p>On 2/18/14 at 8:45 A.M., incontinent care was being provided by CNA #15 and CNA #6. At that time an open superficial area of the left lower buttock/thigh approximately the size of a quarter and an open superficial area of the inner right buttock approximately the size of a nickel was observed.</p> <p>A care plan initiated on 8/22/13, addressed the problem of "...at risk for pressure areas r/t impaired bed mobility, PVD (peripheral vascular disease), bowel incontinence, and hx (history) of pressure ulcers." Interventions included but were not limited to, foam gel cushion to chair, and alternating air mattress to bed. Other care plans dated 2/2/14, indicated a skin problem of the right gluteal fold, and 2/13/14 care plan indicated a skin problem of a left upper posterior thigh blister and a left posterior thigh blister. Interventions included, but were not limited to, pressure reducing mattress and treatment as ordered.</p> <p>On 2/17/14 at 8:57 A.M., Resident #13 was observed in bed on a</p>		<p>ensure care is being provided in accordance with the resident's current needs. The corrective action taken for those residents found to have been affected by the deficient practice is that the nurse identified as ambulating resident #37 at the time of the resident's fall on 2/4/14 has received one on one education on the importance of following each resident's care plan as it relates to the number of staff members required for transfers/ambulation. The nurse was reminded that this information is recorded on the closet worksheet in each resident's room as a quick reference tool to aide in providing care in accordance with each resident's plan of care. The corrective action taken for those residents found to have been affected by the deficient practice is that the CNA who was responsible for transferring the resident identified as resident #56 at the time of the assisted fall on 2/17/14 has received one on one education on the importance of checking daily each resident's closet worksheet to ensure care is being provided in accordance with the resident's current needs as it relates to transfers/ambulation. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been conducted on all residents</p>		

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	<p>synergy air elite mattress. The controls of the bed indicated a blank section (not on) on the minute cycle area of the control panel of the mattress. The comfort control section indicated 5 increments.</p> <p>On 2/18/14 at 11:25 A.M., Resident #13 was observed in bed on his synergy air elite mattress. The control of the bed displayed a blank section on the minute cycle section of the control panel. The comfort control section indicated 5 increments. During interview with LPN #3 at that time she indicated the minute cycle section was blank (not on). She indicated she did not know at what cycle the section should be set . At that time CNA #15 entered the room and was asked about the setting of the mattress control section. She pushed the button of the cycle timer section and the number 5 appeared. She indicated staff had told her it should be on 5.</p> <p>On 2/19/14 at 8:16 A.M., Resident #13 was observed in bed on a synergy air elite mattress. The minute cycle section displayed the number 5. CNA #8 was interviewed at that time. She indicated Resident #13 has had the mattress</p>		utilizing air mattresses to ensure the control settings are in accordance with the manufacturer's guidelines. The audit also consisted of placing the control settings on the treatment records for the nurses to check each shift and the care plans have been updated to include the control settings as well. A house wide audit was also completed to review each resident with an order for breathing treatments to ensure treatments have been scheduled in accordance with the physician's plan of care. No other discrepancies were identified during this audit. All nursing staff members were re-educated on the importance of following the resident's closet worksheet as it relates to the number of staff required for assistance with transfers/ambulation. In addition a house wide audit of the resident's care plans was conducted to ensure information on control settings for air mattresses, breathing treatments, and the number of staff members required for transfers/ambulation be included on the resident's plan of care. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the facility's practices as it relates to air mattresses, following the plan of care related to breathing treatments and following the care		

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	<p>for years. She indicated a wound nurse who used to work at the facility had indicated to "keep alternating on" which she indicated was the minute cycle section of the control area of the mattress. The minute cycle section displayed the number 5. The comfort control section indicated 5 increments.</p> <p>On 2/19/14 at 9:50 A.M., the Director of Nursing (DON) was interviewed regarding the resident's alternating air flow mattress. She was made aware that physician's orders and care plan lacked documentation of setting information and instructions for the alternating air flow mattress. She indicated she did not know at what setting the mattress should be set. She indicated for most Hill-Rom type mattresses she "thought 6 was a standard setting." She also indicated "Shouldn't be turned off." She indicated she was going to ask the maintenance staff for the mattress manufactures's guidelines.</p> <p>On 2/19/14 at 10:25 A.M., a user manual for the synergy air elite mattress low airloss alternating therapy system was received. The manual included, but was not limited to, an alternating therapy mode</p>		<p>plan as it relates to the number of staff required for safe transfers/ambulation for each resident. The nurses were also educated on updating the resident's care plan with any changes in these areas. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor compliance as it relates to the use of air mattresses, administration of breathing treatments and transfers/ambulation being provided in accordance with the resident's plan of care. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The results of the tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>				

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	<p>section which included, "...to start the Alternating Therapy mode, do as follows: 1. Press the Alternate control. The alternate indicator comes on. 2. To set the necessary cycle time interval of the therapy, press the Cycle Timer control to adjust the cycle timer setting in 5 minute increments between 5 minutes and 95 minutes..."</p> <p>2. On 2/17/14 at 10:05 A.M., LPN #10 was observed providing a nebulizer treatment of Ipratropium/albuterol (1 vial) to resident #57.</p> <p>On 2/17/14 at 11:15 A.M., Resident #57's clinical record was reviewed. His admission physician admission orders dated 2/14/14, included, but were not limited to, an order for "Albuterol/Ipratropium 3 ml HHN (hand held nebulizer) q (every) 6 (0 degree symbol for hours) while awake." 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M., medication times were listed.</p> <p>On 2/17/14 at 11:30 A.M., Resident #57's February 2014 medication record (MAR) was reviewed. The MAR included, but was not limited to, the medication Ipratropium/albuterol solution for</p>						

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	<p>HHN q 6 hours while awake. Medication times were 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M. Documentation indicated the treatment had been given starting on 2/14/14 at 5:00 P.M., for the times listed thru 2/17/14 at 9:00 A.M.</p> <p>On 2/17/14 at 2:55 P.M., during interview with the Director of Nursing (DON), she was made aware of the nebulizer treatment being given every 4 hours while awake and not every 6 hours while awake as the 2/14/14 physician order indicated. She indicated at that time she thought the treatment should be given every 4 hours while awake. She indicated she would check with the physician.</p> <p>On 2/17/14 at 3:20 P.M., the DON indicated she had spoken to the physician and the physician indicated he didn't feel it was a medication error but a transcript error. She indicated the physician didn't want the resident awakened for treatment if sleeping.</p> <p>On 2/19/14 at 10:25 A.M., the DON provided a facility policy entitled "Admission of the Resident (policy date 10/98). The policy was reviewed at that time and did not</p>						

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	<p>include medications.</p> <p>3. During an observation on 2/19/14 at 8:45 A.M., Resident #29 was observed in her room, on the 2nd floor of the facility, seated in her Geri-chair. Resident #29 was lifted to her feet from her Geri-chair, then pivoted and seated on her bed by CNA #2. Resident #29 groaned as she was being lifted by CNA #2 from her Geri-chair to the bed.</p> <p>During an interview with CNA #2 on 2/19/14 at 8:50 A.M., CNA #2 indicated she always transferred Resident #29 by herself. CNA #2 indicated the closet work sheet located on the resident's closet door informed CNA's how many people are needed to assist with resident transfers. CNA #2 opened the closet door and pointed to the section on the paper labeled transfers. CNA #2 asked, "Oh when did that change? I didn't know that." CNA #2 indicated that the closet report sheet indicated 2 people were needed to assist with the transfer of Resident #29, but CNA #2 thought</p>						

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	<p>Resident #29 required only 1 person to transfer.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 10/31/13 indicated Resident #30 required the extensive assist of two staff for transfers.</p> <p>An undated, untimed closet report, (notification report form located in the resident's closet which was used by staff to identify a resident's areas of need and the amount of assistance required by that resident for their activities of daily living), for Resident #29 was reviewed on 2/19/14 at 8:50 A.M. It read as follows: "Transfer 2 assist". During an interview, at that time, the ADON (Assistant Director of Nursing) indicated the closet reports were not dated or timed when revised.</p> <p>The clinical record for Resident #28 was reviewed on 2/19/14 at 11:06 A.M. The record indicated Resident #28 was admitted on had diagnoses which included, but were not limited to, dementia, anemia, depression, schizophrenia osteoporosis.</p> <p>4. Resident #37 was observed on 02/12/14 at 11:02 A.M. sitting in a chair in front of the nurses' station</p>						

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	<p>on the 2nd floor of the facility</p> <p>The "Incident/Accident Form" dated 2/4/14 was reviewed on 2/18/14 at 11:10 A.M. The form read as follows: "...Time Occurred: 0530...Type of incident: Fall, assisted...What was the resident doing at the time of the accident? walking down the hall with nurse and decided to sit down on floor..."</p> <p>The Physical Therapy Screen Form dated 2/4/14 read as follows: "...Comments: resident was walking in hall with staff (nursing) and sat down stating he was done with walking no injury. Pt (patient) amb's (ambulates) with HHax2 ((hand held assistance of 2 persons)..."</p> <p>The Clinical record for Resident #37 was reviewed on 2/18/14 at 10:06 A.M. The medical record indicated Resident #37 had diagnoses which included, but were not limited to, unsteady gait, history of burns to upper torso, legally blind, IDDM (insulin dependent diabetes mellities) major depression with reccurent psychotic features.</p> <p>The MDS (Minimum Data Set) assessment, dated 12/19/13, indicated Resident #37 had severe</p>			

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	<p>cognitive impairment. Resident #37 required a 2 person assist with transfers and ambulation. The Care Plan for Resident #37, dated 1/27/14, Risk for Falls read as follows: "Interventions...9. up with two assist for ambulation (na,n) (nursing assistant, nurse)"</p> <p>The Nurse's Notes dated 2/4/14, 0535, read as follows:"Res(resident) fell At 0530 (5:30 A.M.) on floor in hallway. Res was assisted to the floor by this nurse. res stated he was tired of walking and sat down on floor...Alarms were in place but not able to be used since resident walking hall..."</p> <p>The closet report, (notification report form which was located in the resident's closet and used by staff to identify a resident's areas of need and the amount of assistance required by that resident for their activities of daily living), for Resident #37 was reviewed on 2/19/14 at 8:05 A.M. It read as follows: "Transfer 2 assist".</p> <p>5. Resident #56 was observed on 02/17/14 at 10:12 a.m., lying in her Gerrichair, in the dayroom, in front of the TV, on the first floor of the facility.</p>						

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	<p>An "Incident/Accident Form" for Resident #56 dated 2/17/14, was reviewed on 2/19/14 at 11:15 A.M. The form read as follows: "...Time Occured: 1930 (7:30 P.M.)...Type of incident: assisted fall, ...What was the resident doing at the time of the accident? Transferring to bed..."</p> <p>The Clinical record for Resident #56 was reviewed on 2/18/14 at 10:06 A.M. The record indicated Resident #56 was admitted to the facility on 1/16/14. Resident #56 had diagnoses which included, but were not limited to, the following: gastroesophageal reflux disease, hypertension, severe dementia.</p> <p>The nurse's notes were reviewed on 2/18/14 at 4:36 P.M. The nurse's notes read as follows: "2/17/14 1930 (7:30 P.M.) Resident being transferred to bed at this time, resident grabbed onto bedrails and would'nt release bedrail so she could transfer appropriately. Resident assisted to the floor by CNA with no injuries noted..."</p> <p>The closet report, (notification report form located in the resident's closet which is used by staff to identify a</p>			

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	<p>residents areas of need and the amount of assistance required by that resident for their activities of daily living), for Resident #56 was reviewed on 2/19/14 at 8:05 A.M. It read as follows: "Transfer 2 assist".</p> <p>During an interview with the ADON on 2/19/14 at 11:15 A.M., the ADON indicated Resident #56 was being tranfered to her bed by one staff person when the fall occurred. The ADON further indicated that the closet report sheet read that the resident should have been tranfered with the assitance of 2 staff members.</p> <p>A Care Plan for Falls dated 01/29/14 lacked any documentation related to the assistance Resident #56 required for transfers.</p> <p>During an interview with PT#1 on 2/19/14 at 10:57 A.M., PT#1 indicated Resident #56 required the assistance of 2 people when being tranfered because Resident #56 was too unpredictable. PT#1 indicated Resident #56 was on the Physical Therapy (PT) workload and PT was working on standing and pivoting, but PT#1 indicated Resident #56 required 2 people assisting to stand and pivot.</p>			

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F000315 SS=D	<p>During an interview with the Director of Nursing (DON) on 2/19/14 at 10:33 A.M., the DON indicated the facility did not have a specific policy for transferring a resident. The facility used the closet worksheet to identify the method and the number of staff members required to assist with resident transfers and ambulations.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure services were provided to prevent complications of an indwelling catheter, in that, a resident with an indwelling catheter experienced confusion and/or abdominal discomfort and the</p>	F000315	The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #30 has been assessed as it relates to complications with her Foley catheter. The resident will continue to be monitored every shift for the potential for	03/15/2014			

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	<p>catheter was not checked for complications, for 1 of 3 residents who met the criteria for review of urinary catheters. (Resident #30)</p> <p>Findings include:</p> <p>On 02/17/14 at 8:30 A.M., Resident #30 was observed lying in bed with closed eyes. At that time, a catheter drainage bag was observed hanging on the bed frame.</p> <p>The clinical record of Resident #30 was reviewed on 02/17/14 at 12:00 P.M. The record indicated the diagnoses of Resident #30 included, but were not limited to, dementia, anxiety, and urinary retention.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 11/22/13 indicated Resident #30 experienced moderate cognitive impairment.</p> <p>A Physician's Telephone Order dated 02/04/14 indicated an order was received to anchor an indwelling catheter for urinary retention.</p> <p>A Care Plan dated 02/04/14 indicated a problem of, "requires indwelling f/c (catheter) r/t (related to) urinary</p>		<p>complications and appropriate interventions are being taken each shift based on the outcome of each assessment of the resident. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that each resident with a Foley catheter is being monitored each shift by the nurse for the potential of any complications. Appropriate interventions will be provided based on the outcome of each individual assessment of the resident. The measures that have been put into place to ensure the deficient practice does not recur is that the facility has implemented a new policy as it relates to assessment for complications with the use of a Foley catheter. A mandatory in-service has been provided for all nursing staff on the new policy as it relates to monitoring for signs and symptoms of complications in the use of a Foley catheter along with appropriate interventions to treat these potential complications. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor for complications in the use of a Foley catheter. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for 3 months and then quarterly for three quarters. The</p>		

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	<p>retention" with interventions that included, but were not limited to, "1. observe for ...confusion, c/o (complaint of) abd (abdominal) ...pain..."</p> <p>A nurse's note dated 02/07/14 at 1830 (6:30 P.M.) "...Urine dk (dark) amber f/c patent..."</p> <p>A nurse's note dated 02/07/14 at 2200 (10:00 P.M.) indicated, "...Res (resident) increased confusion this evening. Trying to stand up unassisted several times stating "I have to p** (urinate)." When reminded (Resident #30) has a catheter 'I have to p***.' Sat on bedside commode, no results..."</p> <p>The note lacked any documentation the indwelling catheter had been checked for complications.</p> <p>A nurse's note dated 02/08/14 at 0430 (4:30 A.M.) indicated, "...Res continues to both use call light at times et (and) at times attempts to get up out of bed unassisted. States she is pregnant et needs to get up. CNA assisted res to w/c (wheelchair) et res is sitting in first floor lobby at this time. Immediately c/o wanting to go to bed. Asks "Why are you making me sit here? I want to go to bed." The note lacked any</p>		<p>results of the tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>		

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	<p>documentation the indwelling catheter had been checked for complications.</p> <p>A nurse's note dated 02/08/14 at 0530 (5:30 A.M.) indicated, "... Res continues to try to stand up unassisted from reclining chair. States 'I need to p**.'" Shown et explained ... has catheter in place. States "Then I have to s*** (Bowel movement), I'm going to s*** everywhere." Toileted no results. Asks why we have (Resident #30) sitting there. Reminded ... has attempted many times et continues to attempt to stand unassisted et that is unsafe ...at this time ...needs 1-2 assist. The note lacked any documentation the indwelling catheter had been checked for complications.</p> <p>A nurse's note dated 02/08/14 at 0700 (7:00 A.M.) indicated, "...res yelling out "Hey Hey Hey ' Res sitting in reclining chair requesting to go to bed. Reminded its close to time for breakfast ... needs to wait for breakfast. Res attempts to pull catheter out, encouraged to leave cath (catheter) bag on w/c..." The note lacked any documentation the indwelling catheter had been checked for complications.</p>			
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	<p>A nurse's note dated 02/08/14 at 0725 (7:25 A.M.) indicated, "...Res sitting in recliner yelling out help help help trying to stand up et scooting self to edge of chair. Resident refused drink when offered. Staff assist of 2 (two) with transfer to w/c to go in dining room for breakfast..." The note lacked any documentation the indwelling catheter had been checked for complications.</p> <p>A nurse's note dated 02/08/14 at 0800 (8:00 A.M.) indicated, "Res has been toileted prior to breakfast, ate few bites of cereal et then stating, 'I need to go, I have to go p**.' Explained to res ... has a catheter. Res propelling self away from table in w/c grabbing @ (at) catheter. Staff assisted res to table again et assist with enc (encourage) to eat more breakfast, ate 50% et drank 240 cc. taken to toilet again et lay down per 2 assist..." The note lacked any documentation the indwelling catheter had been checked for complications.</p> <p>During an interview on 02/19/14 at 2:30 P.M. the DON (Director of Nursing) indicated a specific policy could not be provided, but it was facility practice to check an</p>						

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F000323 SS=D	<p>indwelling catheter for complications if a resident exhibited signs that included, but were not limited to, confusion and/or abdominal discomfort.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision and/or the appropriate number of staff members, as identified by nursing, were used for transfers for 2 of 2 residents who met the criteria reviewed for falls. (Resident #56, Resident #37)</p> <p>Findings include:</p>	F000323	The corrective action taken for those residents found to have been affected by the deficient practice is that the CNA who was responsible for transferring the resident identified as resident #56 at the time of the assisted fall on 2/17/14 has received one on one education on the importance of checking daily each resident's closet worksheet to ensure care is being provided in accordance with the resident's current needs as it relates to transfers/ambulation. The	03/15/2014

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	<p>1. Resident #56 was observed on 02/17/14 at 10:12 a.m., lying in her Geri-chair, in the dayroom, in front of the TV, on the first floor of the facility.</p> <p>The Clinical record for Resident #56 was reviewed on 2/18/14 at 10:06 A.M. The medical record indicated Resident #56 was admitted to the facility on 1/16/14. Resident #56 had diagnoses which included, but were not limited to, the following: gastroesophageal reflux disease, hypertension, severe dementia.</p> <p>Fall 1. An "Incident/Accident Form" for Resident #56 dated 1/25/14 read as follows: "...Time Occurred: 11:55...Type of incident: Fall, Type of injury: Skin tear at elbow ...What was the resident doing at the time of the accident? Attempting to get up and go to toilet...Where was the resident? in front of nurses station."</p> <p>The clinical record was reviewed on 2/18/14 at 10:06 A.M. The nurse's notes read as follows:"1200 Pt (patient) slid out of chair sm (small) skin tear noted to R (right) elbow. ROM (range of motion) WNL (within normal limits)..."</p>		<p>resident's safety interventions are in place and the resident is receiving the assistance of two staff members during all transfers. The care plan has been updated to reflect the number of staff members needed for transfers. The corrective action taken for those residents found to have been affected by the deficient practice is that the nurse identified as ambulating resident #37 at the time of the resident's fall on 2/4/14 has received one on one education on the importance of following each resident's plan of care as it relates to the number of staff members required for transfers/ambulation. The nurse was reminded that this information is recorded on the closet worksheet in each resident's room as a quick reference tool to aide in providing care in accordance with each resident's plan of care. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have been reviewed related to their individualized needs for transfers/ambulation. There have been no additional falls related to lack of supervision and/or inadequate number of staff transferring or ambulating any resident. The measures that have been put into place to ensure the deficient practice does not recur is that a mandatory</p>		

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	<p>During an interview with the ADON on 2/18/14 at 11:15 A.M., the ADON indicated Resident #56's personal alarm sounded, but staff could not get to her in time.</p> <p>Fall 2. An "Incident/Accident Form" for Resident #56 dated 1/30/14 read as follows: "...Time Occurred: 10:15 P.M.,...Type of incident: unwitnessed fall in room between 10:15 P.M., and 0035 (12:35 A.M.), Type of injury: Skin tear to left hand 1 cm by 1.0 cm ...What was the resident doing at the time of the accident? Attempted to get up in room, personal alarm in place, doesn't lock on clothing. 0 ped pad alarm...Where was the resident? on floor head under bed L(left) arm twisted under her body, face down..."</p> <p>The clinical record was reviewed on 2/18/14 at 10:06 A.M. The nurse's notes read as follows: "1/30/14, 0040 (12:40 A.M.) Res (Resident) found on floor face down with head under bed in resident's room by CNA during bed checks at 0035 (12:35 A.M.). Personal alarm was on and clip slipped off clothing. Last check on res at 2215 (10:15 P.M.), asleep in bed..."</p>		<p>in-service has been provided for all nursing staff on the facility's practices as it related to following the plan of care as it relates to the number of staff required for safe transfers/ambulation for each resident. The nurses were also educated on updating the resident's care plan with any changes needed related to the number of staff members needed for safe transfers/ambulation. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the staff to ensure adequate supervision and/or appropriate number of staff members required as it relates to transferring or ambulating residents. The tool also audits the resident's care plans to ensure all appropriate interventions including the number of staff members required for transfers/ambulation are listed on the care plan. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The results of the tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>				

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	<p>During an interview with the ADON on 2/18/14 at 11:15 A.M., the ADON indicated Resident #56's personal alarm clip slid off her clothing on 1/30/14. The ADON further indicated Resident #56's personal alarm clip had been replaced with a locking clip.</p> <p>Fall 3. An "Incident/Accident Form" for Resident #56 dated 2/17/14, was reviewed on 2/19/14 at 11:15 A.M. The form read as follows: "...Time Occurred: 1930 (7:30 P.M.)...Type of incident: assisted fall ...What was the resident doing at the time of the accident? Transferring to bed...."</p> <p>The Clinical record was reviewed on 2/18/14 at 4:36 P.M. The nurse's notes read as follows: "2/17/14 1930 (7:30 P.M.) Resident being transferred to bed at this time, resident grabbed onto bedrails and wouldn't release bedrail so she could transfer appropriately. Resident assisted to the floor by CNA with no injuries noted..."</p> <p>The closet report, (notification report form located in the resident's closet which is used by staff to identify a resident's areas of need and the amount of assistance required by that resident for their activities of</p>						

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	<p>daily living), for Resident #56 was reviewed on 2/19/14 at 8:05 A.M. It read as follows: "Transfer 2 assist".</p> <p>During an interview with the ADON on 2/19/14 at 11:15 A.M., the ADON indicated Resident #56 was being transferred to bed by one staff person when the fall occurred. The ADON further indicated that the closet report sheet read the resident should have been transferred with the assistance of 2 staff members.</p> <p>The Care Plan for Resident #56, dated 1/29/14, Risk for Falls read as follows: "Interventions... 1. meds as ordered 2. keep room clean from clutter 3. notify MD prn 4. fall assessment per policy and prn 5. shoes/gripper socks at all times 6. call light within reach. 7. therapy screen quarterly and prn 8. personal alarm 9. toileting every 2 hours and prn 10. dycem to chair 11. pressure alarm in bed intervention dated. The care plan lacked documentation as to how much assistance Resident #56 required for transfers.</p> <p>During an interview with PT#1 on 2/19/14 at 10:57 A.M., PT#1 indicated Resident #56 required the assistance of 2 staff members when being transferred because Resident</p>						

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	<p>#56 was too unpredictable. PT#1 indicated Resident #56 was on the Physical Therapy (PT) workload and PT was working on standing and pivoting but PT#1 indicated Resident #56 required the assistance of 2 staff members for transferring.</p> <p>2. Resident #37 was observed on 02/12/14 at 11:02 A.M., sitting in a chair in front of the nurses' station on the 2nd floor of the facility.</p> <p>The "Incident/Accident Form" dated 2/4/14 was reviewed on 2/18/14 at 11:10 A.M. The form read as follows: "...Time Occurred: 0530...Type of incident: Fall, assisted...What was the resident doing at the time of the accident? walking down the hall with nurse and decided to sit down on floor..."</p> <p>The Physical Therapy Screen Form dated 2/4/14 read as follows: "...Comments: resident was walking in hall with staff (nursing) and sat down stating he was done with walking no injury. Pt (patient) amb's (ambulates) with HHx2 (hand held assistance of 2 persons)..."</p> <p>The Clinical record for Resident #37 was reviewed on 2/18/14 at 10:06</p>						

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	<p>A.M. The medical record indicated Resident #37 had diagnoses which included, but were not limited to, unsteady gait, history of burns to upper torso, legally blind, IDDM (insulin dependent diabetes mellitus) major depression with recurrent psychotic features.</p> <p>The MDS (Minimum Data Set) assessment, dated 12/19/13, indicated Resident #37 had severe cognitive impairment. Resident #37 required a 2 person assist with transfers and ambulation.</p> <p>The Care Plan for Resident #37, dated 1/27/14, Risk for Falls read as follows: "Interventions...9. up with two assist for ambulation (na,n) (nursing assistant, nurse)"</p> <p>The Nurse's Notes dated 2/4/14, 0535, read as follows: "Res(resident) fell At 0530 (5:30 A.M.) on floor in hallway. Res was assisted to the floor by this nurse. res stated he was tired of walking and sat down on floor...Alarms were in place but not able to be used since resident walking hall..."</p> <p>The closet report, (notification report form which was located in the resident's closet and used by staff to identify a resident's areas of need and the amount of assistance required by that resident for their</p>						

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	<p>activities of daily living), for Resident #37 was reviewed on 2/19/14 at 8:05 A.M. It read as follows: "Transfer 2 assist".</p> <p>During an interview with the Director of Nursing (DON) on 2/19/14 at 10:33 A.M., the DON indicated the facility did not have a specific policy for transferring a resident. The facility used the closet worksheet to identify the method and the number of staff members required to assist with a resident's transfers and ambulation.</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were clinically indicated, in that, non-pharmacologic interventions were not attempted before the administration of an as needed anti-anxiety medication for 1 of 5 residents (Resident #30) and annual attempts were not made to reduce or continue anti-anxiety and/or anti-depressant medications for 1 of</p>	F000329	The corrective action taken for those residents found to be affected by the deficient practice is that the nurses responsible for administering the prn anti-anxiety medication to the resident identified as resident #30 has received one on one education as it relates to documenting the specific relevant non-pharmacologic interventions that were attempted and failed prior to administering this type of medication. The nurses were also instructed on the facility practice of documenting	03/15/2014

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	<p>5 residents (Resident #37) who met the criteria for review of unnecessary medications.</p> <p>Findings include:</p> <p>On 02/17/14 at 8:30 A.M., Resident #30 was observed lying in bed with closed eyes.</p> <p>The clinical record of Resident #30 was reviewed on 02/17/14 at 12:00 P.M. The record indicated the diagnoses of Resident #30 included, but were not limited to, dementia and anxiety.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 11/22/13 indicated Resident #30 experienced moderate cognitive impairment and no behaviors. The MDS further indicated, Resident #30 received anti-anxiety medications routinely during the assessment period.</p> <p>The most recent Physician's Order Recap dated 02/07/14 included, but was not limited to, an order for, "Ativan (an anti-anxiety medication) 0.5 mg (milligram) every four hours as needed for anxiety..."</p> <p>A Care Plan for "Antipsychotropics"</p>		<p>behaviors on the Psychotropic Medication Monthly Flow Record prior to any administration of any prn psychotropic medication. In addition the residents antipsychotics care plan has been updated to include suggested relevant non-pharmacologic interventions to be attempted prior to the administration of the prn anti-anxiety medication. The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #37 is currently being evaluated by the mental health center with consideration being given to the resident's current drug regimen. Upon the resident's return to the facility he will be routinely reviewed for gradual dose reduction in accordance with the guidelines provided by the Centers for Medicare And Medicaid Services. The corrective action taken for the residents having the potential to be affected by the same deficient practice is that the facility has developed and implemented a tracking tool for those residents on prn psychotropic medications. The tool requires that the nurses document the relevant non-pharmacologic interventions that were attempted prior to the administration of any prn psychotropic medication. In addition the consultant pharmacist has conducted a</p>				

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	<p>dated 12/05/13 lacked any documentation related to interventions that should be attempted prior to the administration of prn (as needed) Ativan.</p> <p>The February 2014 MAR (Medication Administration Record) indicated Resident #30 received Ativan 0.5 mg on 02/08/14 and 02/13/14.</p> <p>The February 2014 Nurse's Medication Notes indicated Resident #30 was administered Ativan 0.5 mg as follows:</p> <p>"...02/08/14...0800 (8:00 A.M.) for anxiety, agitation..." The note lacked any documentation non-pharmacologic interventions had been attempted prior to the administration of the prn anti-anxiety medication.</p> <p>"...02/13/14...2030 (11:30 P.M.)...given for anxiety... Interventions X3 (three times) attempted..." The note lacked any documentation specific non-pharmacologic interventions had been attempted prior to the administration of the prn anti-anxiety medication.</p>		<p>house wide audit on all residents receiving either routine or prn psychotropic medications to ensure that gradual dose reductions have been completed in accordance with guidelines provided by Centers for Medicare and Medicaid Services. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses and QMA's on the new prn psychotropic tracking tool with specific instructions on the documentation of non-pharmacologic interventions prior to the administration of any prn psychotropic medication. In addition the consultant pharmacist was instructed by the facility on the facility's expectations as it relates to on-going reviews in accordance with the guidelines provided by the Centers for Medicare and Medicaid Services as it relates to gradual dose reductions. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the supportive documentation that residents receiving prn psychotropic medications have documentation indicating what relevant non-pharmacologic interventions have been attempted prior to the administration of prn psychotropic</p>		

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	<p>The February 2014 Psychoactive Medication Monthly Flow Record indicated Resident #30 experienced no behaviors including, but not limited to, anxiety from 02/07/14 through 02/08/14.</p> <p>A nurse's note dated 02/08/14 at 0700 (7:00 A.M.) indicated, "... res yelling out 'Hey Hey Hey' Res sitting in reclining chair requesting to go to bed. Reminded its close to time for breakfast...needs to wait for breakfast...." The note lacked any documentation non-pharmacologic interventions had been attempted to reduce the anxiety of Resident #30.</p> <p>A nurse's note dated 02/08/14 at 0725 (7:25 A.M.) indicated, "...Res sitting in recliner yelling out help help trying to stand up et scooting self to edge of chair. Resident refused drink when offered... staff assist of 2 (two) with transfer to w/c (wheelchair) to go in dining room for breakfast..." The note lacked any documentation relevant non-pharmacologic interventions had been attempted to reduce the anxiety of Resident #30.</p> <p>A nurse's note dated 02/08/14 at 0800 (8:00 A.M.) indicated, "...Res has been toileted prior to breakfast,</p>		<p>medications. The tool also includes audits to ensure that gradual dose reductions are being provided in accordance with guidelines provided by the Centers for Medicare and Medicaid Services. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The results of this tool will br reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>				

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	<p>ate few bites of cereal et then stating, 'I need to go, I have to go p**.'... Res propelling self away from table in w/c grabbing... Staff assisted res to table again et assist with enc (encourage) to eat more breakfast., ate 50% et drank 240 cc. Gave res. prn Ativan to calm. Taken to toilet again et lay down per 2 assist..."</p> <p>The note lacked any documentation relevant non-pharmacologic interventions had been attempted to reduce the anxiety of Resident #30 prior to the administration of the prn anti-anxiety medication.</p> <p>The nurse's notes for 02/13/14 were reviewed and lacked any documentation Resident #30 had experienced anxiety and/or non-pharmacologic interventions had been attempted to reduce anxiety for Resident #30 prior to the administration of the prn anti-anxiety medication.</p> <p>During an interview on 02/17/14 at 4:00 P.M., the DON (Director of Nursing) indicated no documentation could be provided that non-pharmacologic interventions had been attempted to reduce the anxiety of Resident #30 prior to the administration of Ativan on 02/08/14 and 02/13/14.</p>				

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	<p>During an interview with the DON on 02/19/14 at 2:30 P.M. the DON indicated a specific policy could not be provided, but it was facility practice to attempt non-pharmacological interventions prior to the administration of a prn anti-anxiety medication.</p> <p>2. The Clinical record for Resident #37 was reviewed on 2/18/14 at 10:06 A.M. The clinical record indicated Resident #37 had diagnoses which included, but were not limited to, unsteady gait, history of burns to upper torso, legally blind, IDDM (insulin dependent diabetes mellitus) major depression with recurrent psychotic features, impulse control disorder, psychosis.</p> <p>The Physician orders dated 2/8/14 were reviewed on 2/19/14 at 2:00 P.M., and indicated Resident #37 had been receiving the anti-anxiety medication Klonopin 1 mg three times a day since 11/5/12, the anti-depressant medication Luvox 100 mg 1 daily since 11/21/11, and the anti-depressant medication Lexapro 20 mg once a day since 1/5/12.</p>						

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	<p>A Care Plan for Psychotropic Medications dated 01/26/14 included, but was not limited to interventions of , "...6. Periodic review of meds for possible dose reduction..."</p> <p>During an interview on 2/19/14 at 3:00 P.M., the DON indicated she could not provide documentation to indicate that Klonopin, Luvox, and Lexapro had been considered for reduction or continuation in the previous 12 months. The DON further indicated she could not provide a specific policy for the facility's medication review or gradual dose reduction, but the DON indicated the facility followed the guidelines provided by the Centers for Medicare and Medicaid Services. The DON indicated these guidelines for Gradual Dose Reduction were to conduct reductions within the first year of use, tapering twice in 2 separate quarters; and after the first year, once annually.</p> <p>3.1-48(a)(2) 3.1-48(a)(4)</p>				

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure a resident ' s medications were reviewed by the Consultant Pharmacist, in that, anti-anxiety and anti-depressant medications were not reviewed for reduction or continuation for 1 of 5 residents who met the criteria for review of pharmacy services. (Resident #37)</p> <p>The clinical record of Resident #37 was reviewed on 02/18/14 at 10:06 A.M. The record indicated the diagnoses of Resident #37 included, but were not limited to, major depression with recurrent psychotic features, impulse control disorder, and psychosis.</p> <p>The most recent Physician Order Recap dated 02/08/14 indicated</p>	F000428	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #37 is currently being evaluated by the mental health center with consideration being given to the resident's current drug regimen. Upon the resident's return to the facility he will be routinely reviewed for gradual dose reduction in accordance with the guidelines provided by the Centers for Medicare and Medicaid Services. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the consultant pharmacist has conducted a house wide audit on all residents receiving either routine or prn psychotropic medications to ensure that gradual dose reductions have been completed in accordance with guidelines provided by the Centers for Medicare and</p>	03/15/2014
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	<p>Resident #37 had been receiving Klonopin (an anti-anxiety medication) 1 mg (milligrams) three times a day since 11/05/12, Luvox (an anti-depressant medication) 100 mg 1 daily since 11/21/11, and Lexapro (an anti-depressant medication) 20 mg once a day since 1/5/12.</p> <p>A Care Plan for Psychotropic Medications dated 01/26/14 included, but was not limited to interventions of , "...6. Periodic review of meds for possible dose reduction..."</p> <p>The plan of care lacked any documentation related to specific time frame for medication tapering/continuation review.</p> <p>During an interview on 02/19/14 at 3:00 P.M., the DON indicated she could not provide pharmacy recommendations for the reduction or continuation of Klonopin, Luvox, and/or Lexapro for Resident #37. The DON further indicated, at that time, she could not provide a specific policy for the facility's medication review or gradual dose reduction. The DON then indicated the facility policy was to follow the guidelines provided by the Centers for Medicare and Medicaid Services.</p>		<p>Medicaid Services. The measures that have been put into place to ensure that the deficient practice does not recur is that the consultant pharmacist was instructed by the facility on the facility's expectations as it relates to on-going reviews in accordance with the guidelines provided by the Centers for Medicare and Medicaid Services as it relates to gradual dose reductions. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to ensure gradual dose reductions are being completed in accordance with the guidelines provided by the Centers for Medicare and Medicaid Services. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The results of the tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>				

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	3.1-25(h)			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F000441	The corrective action taken for those residents found to have	03/15/2014	

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	<p>Based on observation, interview, and record review the facility failed to ensure appropriate handwashing and/or hand hygiene was performed, in that, 1 of 5 nurses did not perform handwashing for the recommended 20 seconds while administering medications to 4 of 11 residents (LPN #12, Resident #13, Resident #36, Resident #46, Resident #45) and 1 of 5 nurses did not perform handwashing or hand hygiene before applying gloves and/or between performing procedures for 1 of 1 residents in contact isolation (LPN #10, Resident #57).</p> <p>Findings include:</p> <p>1. On 2/13/14 at 4:12 P.M., LPN #12 prepared and administered 2 tablets of Tylenol 325 mg to Resident #13. As LPN #12 was exiting Resident #13's room, LPN #12 washed her hands in the room sink for a timed 7 seconds.</p> <p>On 2/13/14 at 4:27 P.M., LPN #12 prepared and administered to Resident #36 pills of Omeprazole 20 mg and Doxazosin 4 mg. She then washed her hands for 13 seconds before continuing the medication pass.</p>		<p>been affected by the deficient practice is that upon assessment the residents identified as residents #13, #36, #45 and #46 no negative outcomes have been identified as a result of the nurse identified as LPN #12 lack of following the facility hand washing policy. Residents #13, #36, #45 and #46 are now receiving their medications by nurses who are following the facility policy as it relates to hand washing. The nurse identified as LPN #12 has received one on one education as it relates to the facility hand washing policy. The corrective action taken for those residents found to have been affected by the deficient practice is that upon assessment of the resident identified as resident #57 no negative outcomes have been identified as a result of the nurse identified as LPN #10 not following the facility policy on hand washing and glove usage. The resident identified as resident #57 is now receiving all medications and IV therapy treatments by nurses who are following the facility policy on hand washing and glove usage in accordance with acceptable standards of infection control practices. The nurse identified as LPN #10 has received one in one education as it relates to the facility hand washing policy and glove usage in accordance with acceptable standards of infection control practices. The corrective</p>				

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	<p>LPN #12 then proceeded at 4:35 P.M., to prepare and administer to Resident #46 the oral medication metoprolol 25 mg.</p> <p>The medication pass continued on 2/13/14 at 4:48 P.M. LPN #12 prepared and administered to Resident #45 the oral medications of famotidine 20 mg and quetiapine 100 mg. LPN#12 then washed her hands for a timed 10 seconds. She then continued her evening medication pass.</p> <p>2. On 2/17/14 at 9:40 A.M., LPN #10 indicated he was going to prepare and administer Resident #57's 9:00 A.M. medications. LPN #10 indicated Resident #57 was in contact isolation. LPN #10 began to remove the resident's medications from the resident's supply of medications on the medication cart. LPN #10 did not clean his hands before removing the following pills from the medication cart: triamterene/HCTZ 37.5/25, a multivitamin pill, aspirin 81 mg, and duloxetine 60 mg. He also removed from the medication cart a bottle of eye drops- alphagan 0.2% eye drops, and a hand held inhaler container of</p>		<p>action taken for other residents having the potential to be affected by the same deficient practice is that all of the facility residents have the potential to be affected by this deficient practice however there have not been any reported/identified negative outcomes involving any of the facility's residents. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all staff on the facility's policy as it relates to hand washing, glove usage and acceptable standards of infection control practices. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the application of following facility policy as it relates to hand washing and glove usage in regards to the administration of medications and treatments. This tool will be completed by the Director of Nursing and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The results of the tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>				

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	<p>Symbicort 160/45 mcg. LPN #10 also had a bag of intravenous antibiotic solution of the antibiotic zyvox 600 mg. LPN #10 then donned a gown, mask and gloves in the hallway. LPN #10 then entered the resident's room with the above medications without handwashing.</p> <p>After entering Resident #57's room, LPN #10 informed Resident #57 of the medication administration. LPN #10 proceeded to take the Resident #57's blood pressure (with blood pressure cuff stored in room) and then give the oral medications. LPN #10 next proceeded without handwashing or glove change to flush the Resident #57's picc line and connect the intravenous (IV) antibiotic and began administering the IV medication per IV pump. Next, LPN #10 administered the inhaler Symbocort to Resident #57. LPN #10 then continued wearing the same gloves, and, without handwashing, administered the Alphagan eye drops to each of Resident #57's eyes. LPN #10 then proceeded to remove his mask, gown and gloves, and then washed his hands in Resident #57's bathroom before exiting</p>			

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	<p>Resident #57's room.</p> <p>On 2/18/14 at 3:15 P.M., during an interview with the Director of Nursing (DON), the DON was informed that nursing staff was observed preparing medications for administration without nursing staff first properly cleaning hands. The DON was also informed about the nurse checking blood pressure, administrating intravenous medications and administering eye drops without a change of gloves or handwashing between procedures. The DON indicated she would expect nursing staff to wash hands before donning gloves when a resident was in isolation.</p> <p>On 2/18/14 at 3:25 P.M., the DON provided a facility policy entitled, "Handwashing /Hand Hygiene (revised date December 2009)." the DON indicated the policy contained the handwashing procedure of 20 seconds.</p> <p>The Handwashing/Hand Hygiene policy included but was not limited to: "...5. Employees must wash their hands for at least (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ... e.</p>						

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	<p>Before and after entering isolation precaution settings;...i. Before and after handling peripheral vascular catheters and other invasive devices; ...l. Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure , and lifting a resident)..."</p> <p>3.1-18(b)(l) 3.1-18(l)</p>			