

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00139753.</p> <p>Survey dates: November 13, 14, 15, 18, 19, 20, and 21, 2013</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Survey team: Karina Gates, Generalist TC Courtney Mujic, RN Beth Walsh, RN Tom Stauss, RN</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 21 Medicaid: 67 Other: 22 Total: 110</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.	

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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	Quality review completed on 11/26/13 by Suzanne Williams, RN				

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to honor residents' preference for shower schedules for 2 of 3 residents reviewed of 3 who met the criteria for choices. (Resident #80 and #122)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #80 was reviewed on 11/18/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #80 included, but were not limited to: heart failure, arthritis, and osteoporosis.</p> <p>During an interview with Resident #80 on 11/15/13 at 11:12 a.m., he indicated he did not choose how many times a week he took a shower. He stated, "I get 2 showers a week. I'd like a shower everyday, if I could. They (staff) told me 3 or 4 months ago I could, but they never pursued it,</p>	F000242	<p>1.The Unit Manager met with residents #80 and#122 to make adjustments in the care plan to accommodate their preferences for shower schedules.Care plans were updated. C.N.A assignment sheets were adjusted to reflect resident choice. 2.During resident and family interviews it will be identified what the residents preferred schedule for showering/bathing is. Identification of needed adjustments will be made and the care plan will be adjusted to accommodate their preferences. Facility wide audits of residents for shower preferences completed.3.Staff was inserviced on 12/2/2013 on components of F242; Resident Choice Resident and family interviews will be conducted monthly to include all alert and oriented residents and family members of those residents that are not alert and oriented to determine if the facility is accommodating resident preferences. During regular facility rounds the Social Services Director, Executive Director and</p>	12/21/2013			

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	<p>so I let it go. Things like that happen all the time around here."</p> <p>The 10/16/13 annual MDS (minimum data set) assessment indicated the support provided him for bathing was "one person physical assist." It also indicated he used a wheelchair for mobility.</p> <p>The 9/6/12 ADL (activities of daily living) care plan for Resident #80 indicated he had an ADL deficit related to musculoskeletal impairment. An intervention was to offer/assist/provide showers 2 times weekly and prn (as needed).</p> <p>During an interview with CNA #13 on 11/18/13 at 11:32 a.m. he indicated he knew how many showers to give a resident weekly by his CNA assignment sheet. He indicated the nurses put the information on the sheet.</p> <p>The CNA assignment sheet for Resident #80 indicated his shower days were Monday and Thursday.</p> <p>During an interview with Unit Manager #5 on 11/18/13 at 11:37 a.m., she indicated residents receive 2 showers a week, and it had been that way in the facility for years. She indicated if</p>		<p>Director of Nursing will ask residents if their preferences are being honored.4.The Social Services Director/Designee will meet with resident council two times monthly for 6 months, to ascertain that resident preferences are being met. Results of audits and resident council minutes will be reviewed at the monthly Performance Improvement Meetings and until such time the committee members determine that the facility remains in substantial compliance and recommends discontinuance of the monitoring.</p>				

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	<p>a resident wanted more than 2 showers weekly, they would schedule them for more, but the resident or family would have to let them know. Regarding how a resident would know they could receive more than 2 showers weekly, she indicated there was no process to specifically ask a resident if they were okay with their shower schedule, and "they would have to bring it up."</p> <p>During another interview with Unit Manager #5 on 11/18/13 at 2:25 p.m., she indicated she'd spoken with Resident #80 who informed her he wanted to shower daily on the 3-11 shift. She indicated, she wrote it on an order form so the CNA assignment sheet could be updated to reflect the change.</p> <p>2. The clinical record for Resident #122 was reviewed on 11/18/13 at 11:15 a.m.</p> <p>The diagnoses for Resident #122 included, but were not limited to: dementia, osteoporosis, and multiple sclerosis.</p> <p>During an interview with Resident #122 on 11/13/13 at 2:25 p.m., she indicated she did not choose how many times a week she took a</p>						

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	<p>shower. She stated, "I get 2. I have asked for more, and they said I could only have 2." She indicated she asked a CNA (Certified Nursing Assistant) approximately 7 months ago, but couldn't remember whom. She indicated she was told she had to ask the DON (Director of Nursing), so she "just let it go." She stated, "That would be wonderful if I could get more."</p> <p>The 8/16/13 annual MDS (minimum data set) assessment indicated the support provided her for bathing was "one person physical assist." It also indicated she used a walker and a wheelchair for mobility.</p> <p>During an interview with CNA #13 on 11/18/13 at 11:32 a.m. he indicated he knew how many showers to give a resident weekly by his CNA assignment sheet. He indicated the nurses put the information on the sheet.</p> <p>The CNA assignment sheet for Resident #122 indicated her shower days were Tuesday and Friday. It also indicated to "assist with ADL's and transfers."</p> <p>During an interview with Unit Manager #5 on 11/18/13 at 11:37 a.m., she</p>						

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	<p>indicated residents receive 2 showers a week and it had been that way in the facility for years. She indicated if a resident wanted more than 2 showers weekly, they would schedule them for more, but the resident or family would have to let them know. Regarding how a resident would know they could receive more than 2 showers weekly, she indicated there was no process to specifically ask a resident if they were okay with their shower schedule, and "they would have to bring it up." Regarding whether the CNA responded appropriately to Resident #122 by telling her she needed to go the DON with her shower schedule change request, she indicated, "The CNA's don't know the systems we use to schedule showers, so I think she handled it properly."</p> <p>During another interview with Unit Manager #5 on 11/18/13 at 2:28 p.m., she indicated she'd spoken with Resident #122 who informed her she wanted to shower on the first Saturday of the month in addition to twice weekly, because she went to church on the first Sunday of the month. Unit Manager #5 indicated, "I'm going to write it out now."</p> <p>3.1-3(u)(3)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a pressure ulcer care plan for 1 of 22 residents reviewed for care plans. (Resident #105)</p> <p>Findings include:</p> <p>The clinical record for Resident #105 was reviewed on 11/19/13 at 11:00 a.m. The diagnoses for Resident #105 included, but were not limited to: malignant neoplasm of tonsil, acute venous embolism and thrombosis of unspecified deep vessels of lower</p>	F000279	<p>1. A care plan was developed for resident #105 addressing pressure ulcers. 2. A facility audit was conducted to identify those residents with pressure areas. Identified residents were re-assessed and care plans reviewed to determine provision of care for pressure had measurable objectives and time tables. Residents will be identified through scheduled care plan meetings, the admission process and the ongoing resident assessment instrument (RAI) process. 3. The interdisciplinary team was re-educated on care plans with measurable objectives</p>	12/21/2013			

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	<p>extremity, thoracic aneurysm, and peripheral vascular disease. The resident was admitted on 10/11/13 and readmitted on 10/24/13.</p> <p>A review of a Progress Note, dated 10/11/13 at 22:01 (10:01 p.m.), indicated, "... Patient is present with several wounds to coccyx [sic], L (left) and R (right) buttocks, R and L lateral knee [sic], and foreskin."</p> <p>A review of the 10/31/13 Admission MDS (minimum data set) Assessment, indicated Resident #105 triggered for a pressure ulcer care plan.</p> <p>The care plans for Resident #105 included, but were not limited to: (name of resident) has actual impairment to skin integrity r/t (related to) pvd (peripheral vascular disease), s/p (status post) neck dissection, s/p tracheostomy, left pectoralis major myocutaneous flap, pharyngoplasty reconstruction, hx (history) of femoral bypass, heart cath, stent placement, peg placement; (name of resident) has oral/dental problems r/t poor oral hygiene; (name of resident) is on pain medication therapy r/t cancer squamous cell carcinoma of the tonsil, wounds; and new admission with discharge potential-stay</p>		<p>and timetables. As care plans are cycled through they will be evaluated for objectives and timetables by the Interdisciplinary Team, re-writing/revising as needed. 4. The responsible party for this plan of correction is the DNS\Unit Managers/designee. The DNS\Unit managers will review two residents' records weekly for 6 months then random reviews for 6 months to determine that those residents with pressure areas have current updated care plans addressing measurable objectives care. The results of reviews will be taken to the next monthly Performance Improvement Meeting for discussion and determination that substantial compliance has been met and sustained.</p>		

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	<p>projected to be of short duration.</p> <p>A care plan for actual pressure ulcers was not located within the clinical record.</p> <p>During an interview with the Director of Nursing (DoN), on 11/19/13 at 10:56 a.m., she indicated if a care plan was triggered by the MDS, then there was a care plan meeting to initiate care plans.</p> <p>On 11/20/13, at 10:08 a.m., the DoN indicated a care plan related to the potential for a pressure ulcer was different than a care plan for an actual pressure ulcer. She also indicated she was not able to locate a care plan for actual pressure ulcers, even though the resident came into the facility with multiple pressure ulcers.</p> <p>A Pressure Ulcer care plan, created 11/21/13, was received from the DoN, on 11/21/13 at 2:45 p.m.</p> <p>The DoN indicated, on 11/21/13 at 2:45 p.m., the care plan for actual pressure ulcers was identified as a problem and a care plan was created.</p> <p>3.1-35(a)</p>						

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care plans were revised to reflect ordered therapy and catheter use for 2 of 22 of residents reviewed for care plans. (Resident #51 and #146)</p> <p>Findings include:</p> <p>1. Resident #51's clinical record was reviewed on 11/18/2013 at 11:04 am. Resident #51 was admitted on 7/31/2013. Diagnoses included but were not limited to; toe amputation, Alzheimer's, peripheral vascular</p>	F000280	<p>1. Resident's # 51 no longer resides within the facility. Resident's #146 care plans for catheter use were reviewed and revised. 2. Audit conducted of those current residents with foley catheters to determine that care plans reflected ordered care and justification for use. Audit was conducted of current residents receiving therapies to determine that care plans reflected ordered therapy. No negative outcomes were identified to those residents identified. Residents will be identified during scheduled clinical meetings. 3. Licensed nurses will be re-educated on: Appropriate physician orders for</p>	12/21/2013			

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	<p>disease, and diabetes.</p> <p>An MD order, dated 7/31/2013 with no time specified, indicated, "Therapy evaluation & treatment: Physical."</p> <p>Review of Resident #51's ADL (activities of daily living) care plan indicated there was no mention of physical therapy rehabilitation needs and or goals.</p> <p>An interview with Physical Therapist #10, on 11/18/2013 at 11:20 pm, indicated, "the resident was non-ambulatory (could not walk) upon admission. She started physical therapy on admission and was discharged from therapy because she was not improving. She was staying the same."</p> <p>A "Physical therapy discharge summary", dated 10/17/2013 with no time specified, indicated, "Patient met highest potential and d/c (discharge) from PT (Physical Therapy)..."</p> <p>An interview with the (Director of Nursing Services) DNS, on 11/20/2013 at 12:43 pm, indicated the MDS (Minimum Data Set) nurse, and the unit manager meet weekly. Together they are responsible for updating any care plan at that time.</p>		<p>catheter use, justification for catheter use and care plan review and revision.As care plans are cycled through they will be evaluated for objectives and timetables by the Interdisciplinary Team, re-writing\revising as needed. DNS or designee will audit/review monthly residents who have catheters to determine accurate orders, assessment, and justification and care plan revision. Infection control log will accurately reflect those residents that present with nosocomial and or HAI infections. Resident infection control log will be maintained by the Director of Nursing. During regular scheduled care plan meetings therapy rehabilitation needs and goals will be addressed. 4. The DNS/ designee will do weekly random reviews of those residents with catheters to determine accurate physician orders and care plan revisions. The DNS/designee will review therapy rehabilitation care plans to determine appropriate reviews and revisions have occurred. Reviews will continue weekly for 6 months then decrease to monthly for 6 months.DNS/designee will additionally monitor for accurate and appropriate resident and family education relative to catheter use.Infection control rates will be reported at the monthly PI meeting any issues identified will be immediately corrected and reported to the</p>				

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	<p>An interview with the DNS, on 11/21/2013 at 2:05 pm, indicated "We don't typically care plan when a resident is on therapy, how many times per week to go to therapy or anything like that. The therapy department usually writes their own care plan for the resident."</p> <p>2. The clinical record for Resident #146 was reviewed on 11/15/13 at 10:39 a.m.</p> <p>On 11/16/13 at 2:27 p.m., Resident # 146 was observed to have Foley catheter in place. She was observed to be lying in bed with catheter hanging from bedside. Urine in Foley collection bag was yellow and observed to be without sediment.</p> <p>On 11/19/13, an 11/15/13 telephone order indicated to DC (discontinue) Foley catheter due to no justification for catheter. Another order, dated 11/18/13 was then observed in clinical record which indicated "D/C (discontinue) order to D/C Catheter" with no indication listed for the order.</p> <p>Resident's diagnoses included, but were not limited to: multiple sclerosis; paraplegia NOS (not otherwise specified); muscle weakness-general; chronic pain syndrome; debility NOS.</p>		Executive Director. Report of these findings will be discussed with the Performance Improvement Committee and presented at the monthly PI Management Meeting to determine if compliance has been met and discontinuation of monitoring is recommended.				

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	<p>During an interview with Unit Manager #5 on 11/19/13 at 10:22 a.m. she indicated that resident originally had the catheter for a sacral/coccyx pressure sore. She indicated the pressure sore has been resolved for "quite awhile." She also indicated that the current Foley catheter order indication of "R/T (related to) Stage 4 Wounds" is no longer valid and should be updated with a new indication for the indwelling catheter.</p> <p>On 11/19/13 at 10:55 a.m., during an interview with DON, she indicated that she was not sure why the resident continued to have a catheter since the pressure sore has resolved. She believed the resident had diagnoses of "chronic intractable pain", MS (multiple sclerosis), among other diagnoses.</p> <p>On 11/20/13 at 12:57 p.m., during an interview with Resident # 146's husband, who is POA for Resident # 146, he indicated that he has observed occasions in the past, most recently "8 weeks ago" where the resident was being treated for a urinary tract infection. He indicated that Resident # 146 had "6 or 7" urinary tract infections since December of 2012.</p>			

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	<p>On 11/21/13 at 9:48 a.m., during a record review of the facility "Infection Control Log," it indicated that Resident acquired 6 urinary tract infections with the following "Onset dates": 12/23/12, 4/5/13, 5/8/13, 6/4/13, 7/11/13, and 8/28/13.</p> <p>An August 2013 care plan for Resident #146 indicated the following: "Resident has Indwelling Catheter: Neurogenic bladder." Indicated interventions include, but are not limited to, "Catheter: has 16fr/30cc..." catheter.</p> <p>On 11/20/13 at 1:52 p.m., during an observation of catheter care for Resident #146, RN #9 indicated Resident #146 has a Foley catheter of size 22 fr (french).</p> <p>Physician's orders from October and November 2013 indicated an order for Foley catheter to be 22 french size.</p> <p>On 11/21/13 at 2:07 p.m., during an interview with Staff Development Coordinator,(who was also the Infection Control Coordinator for the facility) and DON, both indicated that staff should have updated care plans for Resident # 146 regarding use of indwelling Foley catheter to include</p>			

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	<p>additional interventions subsequent to each incidence of urinary tract infection.</p> <p>3.1-35(b)(2)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to record meal intake percentages as care planned for 1 of 22 residents reviewed for following the plan of care. (Resident #191)</p> <p>Findings include:</p> <p>The clinical record for Resident #191 was reviewed on 11/15/13 at 10:30 a.m.</p> <p>The diagnoses for Resident #191 included, but were not limited to: end stage renal disease.</p> <p>The 7/1/13 dialysis care plan for Resident #191 indicated an intervention was to "monitor/document food/beverage intake at meals."</p> <p>The September, 2013 "Individual Resident Meal Intake Record" for Resident #191 indicated no entries for the following meals: 1st Breakfast, 2nd, Breakfast and Lunch, September 4th Breakfast, September</p>	F000282	<p>1. Resident #191 MD was notified of meal intake documentation. Resident was assessed and care plan reviewed and revised. Meal intake record of resident # 191 will be completed as required. 2. A facility-wide audit was completed for current active residents to determine that meal intake records were completed as ordered. Unit managers will monitor completion of meal intake records daily during regular scheduled work hours. Weekend Supervisor will monitor completion of meal intake records during weekend hours.. 3. The nursing staff will be in- serviced on completing meal intake records. DNS\designee will review meal intake records during daily facility rounds during scheduled working hours. Identified areas of concern will be immediately addressed with additional education. 4. The DNS\Designee will perform the following audits: Audit 10 resident meal intake records weekly. Auditing will continue for 12 months The DNS/designee will immediately notify the Administrator of any non-compliance issues. Additional education will be</p>	12/21/2013			

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	<p>5th Breakfast and Dinner, September 6th Breakfast and Lunch, September 8th / 9th all meals, September 10th Lunch and Dinner, September 12th dinner, September 13th lunch, September 14th dinner, September 15th all meals, September September 16th Dinner, September 20th Breakfast, September 30th Breakfast and Lunch.</p> <p>The October 2013 "Individual Resident Meal Intake Record" for Resident # 191 revealed no entries for the following meals: October 1st through October 8th all meals, October 9th Breakfast and Dinner, October 12th Dinner, October 13th Lunch, October 14th Dinner, October 15th all meals, October 16th Dinner, October 20th Breakfast, October 24th through October 27th Breakfast and Lunch, October 30th Breakfast and Dinner, and October 31st all meals.</p> <p>During an interview with the Registered Dietitian on 11/20/13 at 9:52 a.m., she indicated Resident #191's meal intakes should be recorded daily with each meal. She confirmed the percentages were missing for the dates indicated above.</p> <p>On 11/20/13 at 10:22 a.m., during an interview with the Staff Development</p>		<p>provided with any identified issues. Results of findings will be reviewed at the monthly Performance Improvement Committee Meeting and continue until substantial compliance has been achieved</p>				

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	<p>Coordinator she indicated the expectation for nursing to complete the Meal Intake Record was to complete the record for all meals each day. She indicated Resident #191's September, 2013 and October, 2013 Meal Intake Records were not correctly documented by staff for the dates/meals listed above. She indicated, "CNA's usually fill those meal forms out."</p> <p>On 11/20/13 at 10:31 a.m., during an interview with the DON, she indicated the expectation for nursing to complete the Meal Intake Record was to complete the record for all meals each day. She indicated Resident #191's September, 2013 and October, 2013 Meal Intake Records were not correctly completed by staff for the dates/meals listed above.</p> <p>3.1-35(g)(2)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to follow up with a wound care recommendation for 1 of 3 residents reviewed for pressure ulcers, out of 6 residents who met the criteria for pressure ulcers (Resident #105).</p> <p>Findings include:</p> <p>The clinical record for Resident #105 was reviewed on 11/19/13 at 11:00 a.m. The diagnoses for Resident #105 included, but were not limited to: malignant neoplasm of tonsil, acute venous embolism and thrombosis of unspecified deep vessels of lower extremity, thoracic aneurysm, and peripheral vascular disease. The resident was admitted on 10/11/13 and readmitted on 10/24/13.</p> <p>A review of Progress Note, dated</p>	F000314	<p>1. Resident #105 was assessed by Nurse practitioner on 11-20-2013 prior to survey exit. Resident heels were assessed and found to have no open areas, however resident refuses to offload. Care Plan was revised to reflect resident's refusal to wear boots/offload. Plan of care was discussed with resident at bedside regarding pressure re-distribution</p> <p>2. Audit was conducted using the last 30 days of wound care recommendations to determine recommendations were followed up on. Any identified areas of concern were immediately addressed. An audit was conducted to ensure residents had the appropriate recommended pressure reducing/offloading devices present. Care plans were reviewed and revised as appropriate</p> <p>3. Licensed staff was re-educated on following up on recommendations timely</p>	12/21/2013			

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	<p>10/11/13 at 22:01 (10:01 p.m.), indicated, "... Patient is present with several wounds to coccyx [sic], L (left) and R (right) buttocks, R and L lateral knee [sic], and foreskin."</p> <p>A review of a (name of wound care company) Progress Note, dated 10/30/13, indicated, "Plan...add offloading boots bilateral heels; pt (patient) high risk for additional skin breakdown."</p> <p>A review of a (name of wound care company) Progress Note, dated 11/13/13, indicated, "Plan...Boots to bilateral heels at all times in bed."</p> <p>No orders were located in the clinical record regarding the bilateral boots to Resident #105's heels.</p> <p>During an observation on 11/21/13 at 9:05 a.m., Resident #105 was in bed and did not have bilateral boots on.</p> <p>During an interview, on 11/21/13 at 9:10 a.m., Resident #105 indicated they have not worn their bilateral boots in quite some time.</p> <p>A review of the 10/18/13 5 day MDS (minimum data set) Assessment, indicated Resident #105 had a BIMS (brief interview mental status) of 13,</p>		<p>Licensed nursing staffs participate in ongoing educational training regarding wound care, prevention, documentation and the treatment of wounds.C.N.A assignment sheets have been updated to reflect pressure reducing/offloading devices4. The party responsible to monitor this plan of correction is the DNS or Designee.Audits will be conducted 2 times weekly, on 5 residents to determine that pressure reducing devices are in place as ordered; Care Plan updated, Assessments and weekly skin sheets are completed. Auditing will continue for 6 months then decrease to random weekly audits for 6 months.Results of these findings will be presented at the monthly Performance Improvement meeting until such time substantial compliance is achieved and the committee recommends the findings no longer need reported at the monthly PI meeting.</p>		

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	<p>which was indicative of cognitively intact.</p> <p>On 11/21/13 at 10:20 a.m., Resident #105 was observed in bed, without bilateral boots on.</p> <p>At 10:35 a.m., on 11/21/13, the Wound Care Nurse indicated the resident does have boots but hasn't worn them in awhile and the Resident does not like to wear them. She also indicated she will look for any order regarding the bilateral boots.</p> <p>During an interview with the Wound Care Nurse, on 11/21/13 at 11:25 a.m., she indicated she was unable to find any orders regarding the bilateral boots. She also indicated when the (name of wound care company) NP (Nurse Practitioner) came in to provide care, the NP tried to go over the plan of care at the bedside of the resident. The Wound Care Nurse was unable to recall if boots were ever mentioned during the bedside plan of care. The Wound Care Nurse then indicated it was her responsibility to go over the (name of wound care company) Progress Notes. She indicated she doesn't always have time to do that, since she was the only wound care nurse in the facility. The Wound Care Nurse indicated if</p>				

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	<p>she reviewed the notes from 10/30/13 and 11/16/13, she would've clarified with the (name of wound care company) NP about an order/plan of care regarding the bilateral boots. She also indicated it was "human error-I'm sorry."</p> <p>A Pressure Ulcer care plan, created 11/21/13, indicated an intervention, dated 11/21/13, "Heels off loaded [sic] when in bed when resident allows. Resident refuses to wear boots and socks."</p> <p>3.1-40(a)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident was supervised in order to avoid potential accidental ingestion of water in a resident who could not drink water for 1 of 4 residents reviewed for accidents. (Resident #112)</p> <p>Findings include:</p> <p>Resident #112's clinical record was reviewed on 11/19/2013 at 2 pm. Resident #112's diagnoses included but were not limited to; Huntington's disease, tracheostomy status.</p> <p>An MD order, dated 8/5/2013 with no time specified, indicated, "Diet: NPO (nothing by mouth)."</p> <p>Review of Resident #112's hospital records, dated 11/12/2013 at 12:54 pm, indicated, "Patient presents with: Pulled out trach this am at (long term care facility name). Patient then reportedly "got ahold of some water" and experienced difficulty breathing.</p>	F000323	<p>1. Staff reviewed events of this issue, with a focus on documentation and communication, care planning, and interventions related to dietary non-compliance. Facility reviewed with attending MD when non-compliance with diet was identified. Registered Dietician reviewed resident to make sure non-compliance issues had been addressed. Care Plans were reviewed to assure current plan of care. Resident is followed weekly in nutritional meeting held by IDT members. 2. Audit was conducted to identify any resident with NPO status and g-tube feeding, while additionally fluid seeking. No other resident was identified. 3. Licensed staff reviewed the importance of identification of issues that need to be care planned. MD notification of non compliance in dietary issues or change in condition (including behaviors) was stressed as a requirement as licensed nurse follow their standard of practice. Staff were re-educated on Care Planning; and Intervention Implementation. Resident will be moved to an area of safety with additional supervision when fluid</p>	12/21/2013			

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	<p>Patient now exhibiting no SOB (shortness of breath) or distress. On arrival here, she did not demonstrate any respiratory distress. Her lungs are clear. She does not show any signs of aspiration at this time."</p> <p>An observation of Resident #112, on 11/19/2013 at 11:19 am, indicated the resident was sitting up in her geriatric chair in her room. She was positioned approximately 3 feet away from her oxygen tank. She was reaching for the water canister attached to her oxygen tank. She was reaching out and then bringing her arms back up to her face, like she was trying to drink from it. LPN #9 went into her room at this time and pushed the oxygen tank out of the resident's reach. Further observation of the resident at 11:24 am indicated she was coughing, and the nurse went back into her room.</p> <p>An interview with LPN #9, on 11/19/2013 at 11:30 am, indicated the resident did not actually get it to her mouth, "I caught her just in time. She did not drink any water." She was unsure if she's ever tried to do this before.</p> <p>A care plan, dated 11/13/2013 with no time specified, indicated, "Focus: Potential for injury related to</p>		<p>seeking behaviors occur.4.The monitoring of this plan of correction will be a joint effort between the facility NHA and the Director of Nursing as they randomly review 3 residents weekly for 6 months then random weekly reviews for 6 months to determine dietary compliance and care plans that reflect current plan. Any concerns identified through this audit will be addressed immediately. Report of these findings will be presented at the next Performance Improvement Committee Meeting to determine if compliance has been achieved.</p>		

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	<p>equipment in room...Goals: Resident will have no further injuries related to articles in room. I.E. feeding pole, fluids, suction machine. Interventions:...Will keep all trach supplies and needed equipment out of resident's reach."</p> <p>An interview with CNA #4, on 11/21/2013 at 12:14 pm, indicated "I've seen her one time with the suction canister in her hands (full of what had already been suctioned out). I didn't actually see her drink it, but she looked like she was trying to drink from it."</p> <p>An interview with Unit Manager #5, on 11/21/2013 at 12:15 pm, indicated, "all the staff are always watching her and interacting with her to keep her safe."</p> <p>An interview with CNA #6, on 11/21/2013 at 1:50 pm, indicated she is aware that Resident #112 tries to get water to drink. She also indicated, "When I work with (Resident #112), I try to keep her as far away as possible from water. I keep the IV pole or the oxygen tank as far away as possible from her because she can't really move herself closer to it, she can only get to it if she is put close to the water."</p>			

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	<p>An interview with Unit Manager #5, on 11/21/2013 at 2:18 pm, indicated "we try to keep her as far away as possible from the humidified oxygen. Sometimes RT (Respiratory Therapy) might leave her close enough to it, but I will talk with them and remind them she needs to be far enough away. We keep as much of the supplies and things she needs closed in her bathroom where she can't reach them."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F000327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview and record review, the facility failed to properly assess a resident as a dehydration risk and plan/provide interventions to ensure proper hydration, which resulted in a hospital stay with a primary diagnosis as dehydration, for 1 of 1 resident reviewed for tube feedings. (Resident #105)</p> <p>Findings include:</p> <p>The clinical record for Resident #105 was reviewed on 11/19/13 at 11:00 a.m. The diagnoses for Resident #105 included, but were not limited to: malignant neoplasm of tonsil, acute venous embolism and thrombosis of unspecified deep vessels of lower extremity, thoracic aneurysm, and peripheral vascular disease. The resident was admitted on 10/11/13 and readmitted on 10/24/13.</p> <p>A review of the Dehydration Screen, dated 10/11/13, indicated the resident did not have any of the potential risk factors listed, including dependence upon others for fluids and diuretic use. The Dehydration Screen</p>	F000327	<p>1. Resident # 105 was re-assessed and care plans reviewed and revised. Orders for enteral feedings and flushes were reviewed and care plan updated 2. Audit was conducted to identify those residents receiving enteral feedings. Assessments were completed and care plans were updated. Any identified issues were immediately reported to the attending physician for correction 3. The Registered Dietitian will assess all enteral feed residents' fluid needs upon admission and current residents' on enteral feedings and make recommendations for adjustments in fluid for these resident who may have increased needs. Review of residents receiving enteral feeding will be discussed during the weekly nutritional meeting held with the IDT team Fluid needs of these residents will be documented in their plan of care. Licensed staff has been re-inserviced regarding importance of adequate hydration for residents on enteral feeding as well as transcription of enteral feeding and flush orders to the residents MAR. Additional education regarding assessment of those receiving enteral feedings has been provided to</p>	12/21/2013	

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	<p>indicated if any of the risk factors were checked, including diuretic use and dependence upon others for fluids, "further evaluation is required."</p> <p>A review of the Admission Orders, dated 10/11/13, indicated Resident #105 had an order for furosemide (diuretic) 40 mg (milligrams) to be given daily via g-tube (gastronomy tube). The Admission Orders also indicated the resident was N.P.O (nothing by mouth) and was to receive parenteral nutrition orders. A Physician's Order dated 10/15/13 indicated the resident was to receive 200 ml (milliliters) flushes every 4 hours.</p> <p>A review of a Progress Note, dated 10/11/13 at 22:01 (10:01 p.m.), indicated, "...Patient has a PICC line (IV) in RUE (right upper extremity), and also has a Foley [sic] catheter...Patient is on IV ABT (antibiotics) (Zyvox). Patient has NKA (no known allergies). Patient is not ambulatory at this time. Patient is present with several wounds to coccyx [sic], L (left) and R (right) buttocks, R and L lateral knee [sic], and foreskin. Patient is on continuous feeding Vital ADF 1.2 @ 60 ml/hr (milliliters), and 200 ml flush q (every) 4 hr (hour)."</p>		<p>licensed staff. 4. The DNS\designee will review all tube feeding orders weekly times 6 months, then randomly for 6 months to assure that all orders, including rate, flush amount, and accordingly transcribed to the MAR and TAR. They will also review nurse's notes to assure that there is documentation in the resident's chart addressing, but not limited to tolerance to enteral feeding, patency of tube, any S/S of aspiration and/or infection at G-Tube site as well as any signs and symptoms of dehydration. Report of these findings will be discussed at the monthly Performance Improvement meeting to determine that substantial compliance has been met.</p>				

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	<p>A Bed Safety evaluation, dated 10/11/13, indicated, "unable to get out of bed without assistance."</p> <p>The 10/18/13 5 day MDS (Minimum Data Set) Assessment, indicated Resident #105 was totally dependent on others for eating with a 1 person physical assist.</p> <p>A lab, dated 10/11/13, indicated a Blood Urea Nitrogen (BUN) was elevated at 47 mg/dl (possible indication of dehydration), with the normal range being 8-26 mg/dL.</p> <p>A lab, collected on 10/20/13 and reported on 10/21/13 at 8:22 a.m., indicated a BUN/Creatinine ratio of 30, with the normal ranges being 6-25 (possible indication of dehydration).</p> <p>A review of the hospital ER records, dated 10/21/13, indicated, " Nursing home resident was brought to the (name of hospital) emergency department from his PCP (Primary Care Physician) office for altered mental status and dehydration." The chief complaint for the ER visit was listed as "dehydration." The HPI (history of presenting illness) indicated, "...His mouth is very dry. He is N.P.O (nothing by mouth). "</p>						

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	<p>The Physical Exam from the ER indicated, "...Very dry mucus membranes," in bold typeface.</p> <p>The ED (emergency department) Medication Administration record indicated a bolus (fast infusion) of 1,000 ml of sodium chloride 0.9% (intravenous (IV) fluids) was administered on 10/21/13 at 13:26 (1:26 p.m.)</p> <p>The hospital records also indicated the Resident received an IV infusion of, dextrose 5% and 0.9% NaCL (sodium chloride) with KCL (potassium chloride) 20 mEq (milliequivalents) on 10/21/13 at 19:35 (7:35 p.m.).</p> <p>The hospital Discharge Summary, dated 10/24/13 at 9:40 a.m., indicated, "The patient was admitted to the hospital on 10/21/2013, discharged October 24th. He suffered dehydration, confusion, weakness, chronic bedsores, encephalopathy [sic]. The patient was admitted to the hospital. He was treated with IV hydration...He was felt that he probably did not have pneumonia as we originally thought...I discharged him and he was discharged back to rehab. Problems, 1. Dehydration, resolved..."</p>			

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	<p>During an interview with PCP #3, on 11/20/13 at 8:02 a.m., PCP #3 indicated the resident should've been seen 3 days prior to when PCP #3 saw him. PCP #3 also indicated, the facility "sat on him over the weekend." PCP #3 also indicated PCP #3 was not able to treat Resident #105 in the office, so PCP #3 sent Resident #150 to the ER for signs and symptoms of dehydration and mental status changes. PCP #3 further indicated, "(Gender of Resident #105) was a mess."</p> <p>In an interview with the Director of Nursing (DoN), on 11/20/13 at 10:08 a.m., she indicated when a resident had a g-tube and was N.P.O, a risk of dehydration was possible. She also indicated the facility tried to look at hospital/admission labs for a resident and will sometimes determine if the resident was a dehydration risk at admission, from the labs. The DoN also indicated the facility had interim care plans, but she was unsure if the facility had a interim dehydration care plan. She indicated she felt the dehydration screen was a good tool, if it was filled out correctly. The DoN indicated Resident #105's dehydration screen was not filled out correctly, if it was, the Resident would</p>			

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	<p>have triggered as a dehydration risk and care plan would've triggered and would've been made quickly. She also indicated signs and symptoms of dehydration include altered lab values, dry mucus membranes, and confusion. The DoN indicated the dehydration care plan for Resident #105 was made after he returned from the hospital.</p> <p>A care plan titled, "(name of resident) has dehydration or potential fluid deficit r/t (related to) use of atb (antibiotic) and risk of increased loose stool, recent uti (urinary tract infection) infection" [sic] was located in the clinical record. It was dated 11/4/13.</p> <p>On 11/21/13 at 10:05 a.m., Resident #105 indicated they were hospitalized about a month ago for dehydration during an interview. The Resident also indicated they felt better after the hospital stay.</p> <p>A review of the 10/18/13 5 day MDS (minimum data set) assessment, indicated Resident #105 had a BIMS (brief interview mental status) of 13, which was indicative of cognitively intact.</p> <p>At 12:00 p.m., on 11/21/13, Speech</p>			

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	<p>Therapy #11 indicated Resident #105 was able to receive pleasure foods, even though he was N.P.O., until his hospital admission. Speech Therapy #11 indicated this included drinks of water, but the Resident was not able to get out of bed on his own and had to ask staff for water. Speech Therapy indicated when she would assess the Resident, the Resident did not seem very interested in pleasure foods though.</p> <p>3.1-46(b)</p>			

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to administer a resident 5 doses of an antibiotic to treat MRSA (methicillin resistant staphylococcus aureus) and VRE (vancomycin resistant enterococcus) in a stage IV pressure ulcer in the sacral/coccyx area for 1 of 1 randomly reviewed resident for infection control. (Resident #105)</p> <p>Findings include:</p> <p>The clinical record for Resident #105 was reviewed on 11/20/13 at 2:00 p.m.</p> <p>The diagnoses for Resident #105 included, but were not limited to: stage 4 pressure ulcer.</p> <p>The 10/24/13 Physician's Order indicated Linezolid 600 mg to be given via G-tube every 12 hours at 12:00 a.m. and 12:00 p.m.</p> <p>On 11/21/13 at 12:53 p.m., during an interview, Resident #105 indicated he did not receive the Linezolid for "the wound on my bottom" for "a couple of days now."</p>	F000333	<p>1. Resident # 105 attending physician was contacted and informed of the medication variance. New orders were received. Family and resident notified of medication variance. Medication variance report was completed. Resident #105 received the ordered medication. Care plans were reviewed and revised. LPN #7 received disciplinary action. 2. A facility audit was conducted to determine that current residents ordered Antibiotics have received them. Care plans were reviewed and updated as applicable. No other resident was identified to have been affected. 3. Licensed staff was inserviced on medication administration, as well as correct transcription of physician orders to the MAR. Consultant Pharmacy was contacted to provide a quality assurance med pas evaluation with on the spot education as needed. 4. The Director of Nursing/designee will monitor through observation, Medication Administration and review of Pharmacy Consultant Report, at least monthly for three months, then quarterly, to assure medications are administered according to physician's orders. Any identified issues will be</p>	12/21/2013	

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	<p>The November, 2013 MAR (medication administration record) indicated the above medication was given twice daily through 11/18/13. It indicated no further administrations of Linezolid were given after 11/18/13.</p> <p>The 11/18/13 MD progress note indicated Resident #105 had a "sacral decubitus" wound measuring 5 x 6 cm. The note also indicated Resident #105 was in the 5th of 6 weeks of scheduled Linezolid antibiotic administrations.</p> <p>On 11/21/13 at 2:58 p.m., during an interview with the front office assistant for (Resident #105's infectious disease physician who wrote the Linezolid order), she indicated the current order for Linezolid should have been continued through "next week" and should not have been discontinued.</p> <p>On 11/21/13 at 1:03 p.m., during an interview, LPN #14 indicated she did not administer the antibiotic, Linezolid, to resident #105 on 11/21/13 because it was discontinued.</p> <p>On 11/21/13 at 3:32 p.m., during an interview, the DON indicated that</p>		<p>immediately addressed. The DNS will report any unresolved concerns at the next monthly Performance Improvement Meeting and or until substantial compliance is achieved and the committee recommends discontinuation of the monitoring.</p>				

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	<p>Resident #105 should have received Linezolid twice daily since 10/24/13, and was not aware of an order to discontinue it. She further indicated, "He will get it today." The DON indicated RN #7 previously received an order from the doctor to discontinue the Linezolid after 11/25/13, but documented the MAR to reflect stopping the linezolid on the incorrect date, 11/18/13. She indicated corrective action would be taken with RN #7.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure the dishwasher reached the minimum temperature necessary to clean dishes which had the potential to affect 96 residents who were served food out of the kitchen of 110 residents.</p> <p>Findings include:</p> <p>An observation and interview with the Dietary Manager (DM), on 11/14/2013 at 3:35 pm, indicated the dishwasher had 2 separate thermometer's needles. 1 thermometer was for wash and 1 was for rinse. The rinse temperature read 172 degrees F (Fahrenheit). The wash temperature read 160 degrees F (Fahrenheit). The wash temperature thermometer didn't move at all, both when the machine was running and when it wasn't running. An orange colored label on the dishwasher machine indicated, "Notice: This machine is in hot water sanitizing mode." The DM indicated,</p>	F000371	<p>1.No resident was adversely affected. 11-14-2013 Eco Lab here to adjust valves 2. Any resident has the potential to be affected 3. Dietary staff will continue to temp out dish machine prior to washing dishes to determine manufactures recommendations re water requirements met. Any identified issue will be immediately corrected 4. Dietary manager\Admin will audit temp of dish machine daily for 3 months then random weekly auditing for 9 months to ensure machine runs in sanitizing mode for dishwashing. Results of audits/ inspections will be taken to Performance Improvement Committee Meetings monthly to determine continued compliance until such time the committee recommends discontinuation of the auditing.</p>	12/21/2013			

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	<p>"This is the first time the needle hasn't moved."</p> <p>The dishwasher's manufacturer recommendations were provided by the DM, on 11/14/2013 at 3:15 pm. The recommendations indicated, "water requirements: Note: Temperatures listed are minimums. Wash temperature (hot water sanitizing) 160 degrees F (Fahrenheit). Rinse temperature (hot water sanitizing) 180 degrees F (Fahrenheit)."</p> <p>An interview and observation with the DM, on 11/15/2013 at 1:00 pm, indicated the dishwasher was now reaching the required temperature. The DM indicated, "The maintenance guy from (name of service company) came in last night and adjusted the valves."</p> <p>3.1-21(i)(3)</p>				

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F000441 SS=E	<p>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. (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. Based on observation, interview, and record review, the facility failed to</p>	F000441	1. Residents #40, #105, and #115 were assessed. No	12/21/2013			

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	<p>provide medication in a sanitary manner for 2 of 6 residents reviewed for medication administration (Resident #40 & #115) and the facility also failed to remove contaminated gloves before touching a resident's Foley catheter tubing/bag for 1 of 2 residents reviewed for wound care observations (Resident #105).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a medication administration observation, on 11/18/13 at 9:11 a.m., RN #1 pulled a Spriva (inhaler) 18 mcg (micrograms) pill out of the packaging with their bare hands and placed the medication in the inhaler for use by Resident #40. RN #1 then administered the medication to Resident #40. 2. During a medication administration observation, on 11/18/13 at 9:40 a.m., LPN #2 pulled ferrex (iron pill) 150 mg (milligrams) out of its packaging with their bare hands and placed the medication in a medication cup to be administered to Resident #115. LPN #2 then administered the medication to Resident #115. <p>During an interview with the Director of Nursing (DoN), 11/18/13 at 2:13 p.m., she indicated there was never</p>		<p>negative outcome was identified. RN #1 and Lpn #2 were educated on infection control practices related to medication administration. Wound Nurse was educated on infection control practices related to dressing changes. 2. Any resident that received medications on 11-18-2013 from RN#1 and Lpn #2 had the potential to be affected. No negative outcomes were identified. Any resident that received wound care on 11-21-2013 per facility wound care nurse had the potential to be affected; however no negative outcomes were identified. All residents with an infection were reviewed to ensure appropriate procedures in place. No discrepancies noted. 3. Licensed staff will be educated on infection control practices upon hire and at least annually. Re-education was provided to the facility licensed staff regarding infection control practices for medication administration and wound/dressing changes, with focus on changing gloves when contaminated. Additionally, nursing staff will be educated on isolation practices to prevent the transmission of disease and infection. The DNS/Designee will conduct an observational audit of medication administration and dressing changes 3 times weekly to include all shifts to ensure adherence to infection control practices. The monthly infection</p>				

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
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	<p>an appropriate time that Nursing Staff should touch medication/pills with their bare hands and administer the medication to a Resident.</p> <p>3. During a wound treatment observation, for Resident #105, on 11/21/13 at 10:10 a.m., the Wound Care Nurse provided treatment to a wound on the left buttocks and after she placed the dressing on the wound, she kept her gloves on. The Wound Care Nurse then moved the Resident's Foley catheter from one side of the bed to the other side of the bed, touching the catheter tubing and the catheter bag, with her gloves still on from the wound treatment.</p> <p>During an interview with the Director of Nursing (DoN), 11/21/13 at 1:10 p.m., she indicated once a staff changes a wound dressing, the gloves were considered contaminated/dirty and the gloves should be discarded before touching anything else.</p> <p>A policy titled, Clean Dressing Change, dated 4/28/10, was received from the DoN on 11/21/13 at 2:00 p.m. A review of the policy indicated, "...18. Apply dressing, and secure as ordered. 19. Remove gloves and discard with all soiled supplies in</p>		<p>control log will be maintained by the Director of Nursing. Any variations will be immediately corrected with the appropriate employee. 4. The DNS/Designee will conduct an observational audit of medication administration and dressing changes 3 times weekly for 3 months then random observations for 3 months to include all shifts to ensure adherence to infection control practices. Any identified issues will be discussed with the Executive Director. Report of these findings will be presented at the monthly Performance Improvement Committee meeting until substantial compliance has been met and the committee recommends discontinuation. 1. Residents #40, #105, and #115 were assessed. No negative outcome was identified. RN #1 and Lpn #2 were educated on infection control practices related to medication administration. Wound Nurse was educated on infection control practices related to dressing changes. 2. Any resident that received medications on 11-18-2013 from RN#1 and Lpn #2 had the potential to be affected. No negative outcomes were identified. Any resident that received wound care on 11-21-2013 per facility wound care nurse had the potential to be affected; however no negative outcomes were identified 3.</p>				

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	plastic bag."		Licensed staff will be educated on infection control practices upon hire and at least annually. Re-education was provided to the facility licensed staff regarding infection control practices for medication administration and wound/dressing changes, with focus on changing gloves when contaminated. Additionally, nursing staff will be educated on isolation practices to prevent the transmission of disease and infection. The DNS/Designee will conduct an observational audit of medication administration and dressing changes 3 times weekly to include all shifts to ensure adherence to infection control practices. The monthly infection control log will be maintained by the Director of Nursing. Any variations will be immediately corrected with the appropriate employee. 4. The DNS/Designee will conduct an observational audit of medication administration and dressing changes 3 times weekly for 3 months then random observations for 3 months to include all shifts to ensure adherence to infection control practices. Any identified issues will be discussed with the Executive Director. Report of these findings will be presented at the monthly Performance Improvement Committee meeting until substantial compliance has been met and the committee		

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	<p>4. The clinical record for Resident #105 was reviewed on 11/20/13 at 1:36 p.m.</p> <p>On 11/20/13 at 2:13 p.m., during an interview, the facility Staff Development Coordinator indicated that she had no knowledge of Resident #105 having had any infection since the most recent pneumonia infection that was listed on the facility's Infection Control Log. She indicated she was the facility person in charge of monitoring infection control measures utilized in the facility and for the training of employees in regards to infection control.</p> <p>A 10/24/13 discharge MD progress note indicated resident was admitted to facility with a stage III - IV sacral wound with "sacral osteomyelitis with MRSA (methicillin resistant staphylococcus aureus) and VRE (vancomycin resistant enterococcus) and included treatment for the infection with linezolid, an antibiotic medication.</p> <p>An MD progress note, from an MD office visit, dated 11/18/13 indicated Resident #105 "presented" with osteomyelitis.</p>		recommends discontinuation.		

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	<p>The November 2013 medication administration record indicated Resident #105 had been administered linezolid twice daily from November 1st through November 18th.</p> <p>During an interview with Unit Manager #8 on 11/20/13 at 1:49 p.m., she indicated Resident #105's wound was being treated with Linezolid for MRSA and VRE.</p> <p>The facility's Infection Control Log was received from the Staff Development Coordinator on 11/21/13 at 9:47 a.m. It indicated facility infections with an onset between 6/2013 and November 14th, 2013. Resident #105 was listed once in the list with Pneumonia, with an onset of 10/11/13.</p> <p>On 11/21/13 at 9:49 a.m., the Staff Development Coordinator indicated the Infection Control Log was a "complete list" of the known facility infections between the above referenced dates. She indicated having no knowledge of any current facility residents having MRSA and VRE in a wound or being treated with antibiotics for a wound infection.</p>			

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	<p>On 11/21/13 at 1:07 p.m., Resident #105 was observed in his room lying in bed. There were two Residents observed to be occupying the room. No isolation precaution signs or placards were on the entry way to the room or in the room to indicate to staff that contact precautions should be observed for Resident #105's care. No isolation cart, containing personal protective equipment was observed outside Resident #105's room and no personal protective equipment was observed in Resident #105's room.</p> <p>3.1-18(b) 3.1-18(l)</p>				