

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155516	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2015
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW MEMORIAL HOSPITAL-CCC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DR FORT WAYNE, IN 46805
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 20, 21, 22, 23 &amp; 24, 2015</p> <p>Facility number: 001203 Provider number: 155516 AIM Number: N/A</p> <p>Census bed type: SNF: 33 Total: 33</p> <p>Census payor type: Medicare: 17 Other: 16 Total: 33</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	This Plan of Correction consitutes our allegation of compliance. Please consider this Plan of Correction to meet the requirements for "paper compliance" versus an on-site re-survey.	

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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F 431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure over the counter medications and topical ointments were labeled with a resident</p>	F 431	1. RN #1 was counseled on the proper procedure for labeling medications in the Pyxis individual resident bins on 4/21/15. 2. Assistant Director of	05/22/2015

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	<p>and physician name for 2 of 3 Pyxis units. (Pyxis SA5-2 and SA5-1)</p> <p>Findings include:</p> <p>An observation of Pyxis station (an electronic medication distribution system) SA5-2 with RN #1 on 4-21-2015 at 9:26 a.m., indicated room number specific compartments contained resident specific labeled medications. The following over the counter medications were not labeled with a resident specific label that included the resident and physician name: a Metamucil packet in the bin marked 1510 a Healthylax packet in the bin marked 1509</p> <p>An interview with RN #1 on 4-21-2015 at 9:30 a.m., indicated the Metamucil and Healthylax packets came from the supply inside the Pyxis and should have been returned to the supply since the packets were not used.</p> <p>An observation of Pyxis station SA5-1 with RN #1 at 9:35 a.m., indicated a tube of Bacitracin with zinc which had been opened did not have a resident specific label and was stored in an unlabeled plastic bag in compartment 1503. In addition, two Spriva capsules were inside</p>		<p>Nursing (ADON) inspected all individual resident bins for labeling compliance on 4/21/15. No other individual medications were out of compliance.3. ADON reviewed Pyxis labeling standard with all staff on duty on 4/21/15.4. Pyxis labeling standards were reviewed in the staff huddles on 4/23/15 and 4/24/15 by DON and ADON.5. The pharmacy policy for Medication Labeling will be reviewed and updated to reflect the standard of placing multiple dose medications in a clear plastic bag and placing a patient label on the bag. 6. Inservices will be conducted for all nurses in medication labeling procedure during the week of May 11, 2015. 7. Quality Monitoring will include: A. Monthly QAA monitoring tool will be used for monthly audits B. All resident Pyxis medication bins will be checked by ADON/QAA RN team member for compliance with labeling policy. Medication bins will be audited monthly. C. Nurse will be given feedback regarding medication labeling compliance immediately after audit is completed. D. QAA monitoring results will be reported, discussed and follow up initiated at the monthly QAA meetings.</p>	

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	<p>the unlabeled plastic bag without a resident specific label and the handi-haler was not in the bag or in compartment 1503.</p> <p>An interview with the ADON (Assistant Director of Nursing) on 4-22-2015 at 10:51 a.m., indicated any topical ointments obtained from the Pyxis should be stored in a plastic bag with a resident specific label with the date opened marked on the label before being stored in the room number compartment of the Pyxis unit. Further interview with the ADON, indicated the medication obtained from the Pyxis for a specific resident and not used, should be returned to the Pyxis or stored in a plastic bag with a resident specific label affixed to the plastic bag and placed in the corresponding room number compartment.</p> <p>An interview with RN #2 on 4-23-2015 at 2:50 p.m., indicated topical medication obtained from the Pyxis should have a resident specific label placed on a plastic bag and the topical medication stored in the plastic bag and in the locked bathroom cabinet in the resident's room. Further interview with RN #2, indicated a packet of Metamucil should be returned to the Pyxis if the resident did not take it or placed in a plastic bag with a resident</p>			

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F 441 SS=E Bldg. 00	<p>specific label affixed to the plastic bag and stored in the room number compartment of the Pyxis.</p> <p>An interview with the Administrator on 4-23-2015 at 4:10 p.m., indicated it was the facility's practice to use resident labels on plastic bags for over the counter medications and topical ointments that were placed in the Pyxis room specific compartments for resident use, but their policy did not reflect the practice.</p> <p>A current policy, "Labeling Standards" dated 1/2012 and provided by the Administrator on 4-23-2015 at 4:18 p.m., indicated "...all drug containers shall be labeled and drug labels must be clear, consistent, legible, and in compliance with state and federal requirements.</p> <p>3.1-25(j)(k)(l)</p> <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>			

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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure reusable glucometer equipment was sanitized between use on multiple residents for 1 of 2 observations of glucometer use.</p> <p>B. Based on observation, interview and</p>	F 441	1. DON reviewed the Infection Control Policy and no revisions are necessary. Completed 4/28/15. 2. Inservices will be conducted for all staff in isolation procedures and glucometer cleaning during the week of May 11, 2015. These inservices will include mobile equipment cleaning, isolation room medication disposal, use/removal	05/22/2015

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	<p>record review, the facility failed to ensure reusable equipment, nurse's personal equipment, and single use medications were cleaned and maintained in accordance with facility policies and procedures for contact precautions for 1 of 2 resident's observed in contact precautions. (Resident #63)</p> <p>C. Based on observation, interview and record review, the facility failed to ensure staff followed contact precautions for personal protective equipment and hand hygiene for 2 of 2 residents identified for contact precautions (Resident #218 and #63).</p> <p>D. Based on observation, interview and record review, the facility failed to ensure gloves were changed after removing a soiled dressing and prior to cleaning the wound, and handwashing or hand hygiene was completed after the wound care procedure and prior to leaving the room for 1 of 1 resident observed during a wound care procedure. (Resident #221)</p> <p>Findings include:</p> <p>A. On 4/22/15 at 11:30 a.m. RN (Registered Nurse) #8 was observed to remove the handheld glucometer out of the charging cradle at the nurses' station. She was observed to enter a resident's</p>		<p>of nursing personal equipment in isolation room, and use of PPE.3. DON reviewed the Dressing Change Policy. No revisions are necessary. Completed 4/28/154. Inservices will be conducted for all nurses in dressing change procedure during the week of May 11, 2015 5. DON reviewed Contact Isolation signage and no revisions are necessary. Completed 4/28/20156. DON discussed the correct procedure for caring for Isolation residents with LPN #7 and RN #4. Completed 5/1/15.7. Director of Nursing (DON) discussed the correct procedure for hand washing and glove removal during dressing changes with RN #5. Completed 4/29/15 8. Lead Therapist reviewed the correct procedure for caring for Isolation residents and hand hygiene with OTR #3. Completed 5/1/15 9. Inservices will be conducted for contracted therapy staff in isolation precautions and hand hygiene the week of May 4, 2015. 10. Quality Monitoring will include: A. Monthly QAA auditing for glucometer cleaning, isolation procedures, and dressing changes will occur. B. Ten (10) glucometer cleaning observations will be done by QAA RN or team member each month.C. Ten (10) observations of staff completing isolation precautions will be done by QAA</p>		

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	<p>room with the glucometer. At 11:35 a.m. RN #8 was interviewed. She indicated this glucometer belonged to the facility and was used on multiple residents. RN #8 was not observed to clean the glucometer prior to using it. RN #8 was observed to don gloves, obtain a blood sample from the resident using the lancet and collected the blood on the glucometer strip. After RN #8 obtained the resident's blood sugar with the glucometer, she was observed to leave the resident's room without cleansing the glucometer. After RN #8 returned to the nurses station, she placed the glucometer back in the charging cradle without cleaning it.</p> <p>On 4/22/15 at 11:40 a.m. RN #8 was observed to leave the nursing station area. At 11:45 a.m. RN #8 returned to the nursing station and took the same glucometer used to check a resident's blood sugar at 11:40 a.m. on 4/22/15. RN #8 was observed to enter a different resident's room to obtain a blood sugar, without having cleaned the glucometer used on the previous resident. Prior to RN #8 having performed a glucometer check on the current resident RN #8 was interviewed. RN #8 indicated she had not cleaned the glucometer from use with the last resident and prior to the usage on this current resident. RN #8 indicated the reason she had not cleaned the</p>		<p>RN or team member each month.D. Ten (10) resident dressing changes will be observed by QAA RN each month.E. Staff feedback regarding compliance will be given immediately after the audit observations. F. QAA monitoring results will be reported, discussed and follow up initiated at the monthly QAA meetings.</p>		

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	<p>glucometer between resident usages was "I forgot." RN #8 was then observed to go to the nurses' desk and obtained the PDI (a type of germicidal wipes) wipes from the cupboard. She was observed to clean the glucometer with the PDI wipes and indicated she would let the glucometer air dry.</p> <p>On 4/23/15 at 9:30 a.m. RN #1 was interviewed. She indicated the glucometer she uses had been used on multiple residents. She indicated after she uses the glucometer, she cleans it with the PDI wipes for 2 minutes and lets it air dry.</p> <p>On 4/23/15 at 1:10 p.m. RN #2 was interviewed. She indicated after completing a glucometer check on a resident, staff were to clean the glucometer with a PDI wipe before exiting the room and placing the glucometer in the docking station/charging cradle. She indicated the PDI wipes were kept in the cabinets at the nurses' station.</p> <p>On 4/23/15 at 3:32 p.m. the ADON (Assistant Director of Nursing) provided current copy of the policy and procedure for "Whole Blood Glucose - AccuChek Inform II Meter." This policy had a "last approval date" of 05/2014 documented.</p>			

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	<p>This policy included, but was not limited to, the following: "...cleaning: Meters must be cleaned and disinfected between each patient use...wipe the surface of the meter after each use...with hospital disposable cloth..."</p> <p>On 4/24/15 at 10 a.m. the DON (Director of Nursing) was interviewed. She indicated staff should clean the glucometers between resident uses with the facility provided PDI wipes.</p> <p>B. On initial tour of the facility on 4/20/15 at 9:15 a.m., Resident #63 was observed to have a sign "Contact Precautions" on her door. The door to her room was also observed to have disposable gowns, gloves and masks stored in an over the door caddy. The sign included, but was not limited to, the following information: "...dedicate use of non-critical patient care equipment to a single patient; clean and disinfect any common equipment..."</p> <p>An observation of RN #4 on 4-21-2015 at 9:45 a.m., indicated the portable vital sign monitor was being wheeled from a contact isolation room, Resident #63's room, to the nurse's station. RN #4 was observed to clean the portable vital sign machine with Super Sani Wipes at the nurse's station and without the use of</p>			

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	<p>gloves.</p> <p>On 4/23/15 at 7:55 a.m. LPN #7 was observed in Resident #63's room. A wheeled, mobile unit which included a blood pressure machine, with cuff, thermometer and pulse oximeter was observed at the resident's bedside. LPN #7 was observed to have a clipboard, pen and individually packaged medications resting on the tray portion of the computer unit at the resident's bedside. LPN #7 was observed to have a dark colored stethoscope hanging around her neck, on the outside of the isolation gown she was wearing. LPN #7 indicated she was preparing medications to give to the resident. She indicated she had removed these medications from the Pyxis (machine in the medication room in which prescription medications supplied by the pharmacy are stored and removed by nursing staff). LPN #7 was observed to go into the resident's bathroom with her gloved hands, get water out of the bathroom faucet in the resident's water cup, all with the same gloved hands. She was then observed to touch the resident's straw and stir the medication powder into the glass of water. LPN #7 indicated prior to preparing the resident 's medications, she had checked the resident's blood pressure.</p>			
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	<p>Resident #63 was observed to be sitting in a chair at her bedside. She was observed to have a gauze dressing taped to her right elbow. The center of the dressing was observed to have an area of dark dried substance, with the outer edges of the dark dried area visible when the resident's elbow was bent in a flexed, downward position. LPN #7 was observed to touch the resident's right elbow dressing with the same gloved hands. She indicated because of the dried drainage, she would contact the wound care nurse to come look at the dressing. Without changing her gloves, LPN #7 was observed to touch her clipboard and pen. After the medication pass was completed, the nurse removed her gloves and gown. She sanitized her hands and then with bare hands picked up her clipboard, the three unused individually packaged medications and pen and left the room. LPN #7 did not clean the mobile vital sign unit, pen, clipboard and/or the packaged medications.</p> <p>On 4/23/15 at 8:41 a.m., LPN #7 went into the medication room and returned three medications to the Pyxis machine. She accessed the Pyxis machine by entering her codes and then placed the three medications in a bin inside the top drawer. She indicated these medications would be "recirculated" by pharmacy.</p>			

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	<p>On 4/23/15 at 10:35 a.m. LPN #7 was observed in Resident #63's room and she was preparing to give the resident a breathing treatment. LPN #7 was observed with disposable gown and gloves on and a dark color stethoscope around her neck. LPN #7 had placed her clipboard and pen on the computer table in the resident's room. Resident #63 remained in contact precautions. LPN #7 was observed to take the dark colored stethoscope from around her neck and assess the resident's breath sounds. When the assessment was completed, she replaced the stethoscope around her neck, with the gloved hands. When the treatment was completed, LPN #7 took the nebulizer from the resident and replaced it in the bag at the bedside. She was observed to remove her gown and gloves. She then picked up her clipboard and pen. A visitor in the room indicated to LPN #7 "You forgot something", while he pointed to the yellow stethoscope on the table part of the computer unit. LPN #7 indicated "Oh no, that's the extra one that stays in the room." LPN #7 was not observed to clean the portable vital sign machine and/or her stethoscope around her neck, prior to leaving the isolation room. LPN #7 then pushed the unclean vital sign machine unit out to the nursing station, got the PDI wipes from the</p>			
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	<p>nurses ' station and wiped down the vital sign unit. LPN #7 kept the dark colored stethoscope around her neck and without ever cleaning it.</p> <p>On 4/23/15 at 2 p.m. LPN #7 was observed to still have on the dark colored stethoscope around her neck which she was observed to have earlier in the morning.</p> <p>On 4/24/15 at 9:30 a.m. the ADON (Assistant Director of Nursing) was interviewed. She indicated the following: Resident #63 was currently in Contact Precautions due to diagnosis of MRSA (Methacillin Resistant Staphylococcus Aureus). She indicated the resident had been admitted to the facility on 4/10/15 and had a physician order for contact precautions at that time. She indicated the resident had a positive MRSA nasal swab while in the hospital on 2/6/15 and since then had a negative nasal swab for MRSA in the facility on 4/16/15. The ADON indicated if a resident had a history of MRSA, they are "flagged" in the system. She indicated when resident's are "flagged" in the system, it means the resident was to be in isolation. She indicated Resident #63 is currently "flagged" in the system.</p> <p>On 4/22/15 at 11:30 a.m. the ADON</p>			

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	<p>(Assistant Director of Nursing) provided the current copy of the facility policy and procedure for "Multi-Drug Resistant Organisms and MRSA (Methacillin Resistant Staphylococcus Aureus) Screening." This policy was dated 4/2012. This policy and procedure included, but was not limited to, the following: "MRSA...a resistant strain...that is capable of causing serious infections throughout the body. Colonization may occur in the nares or on moist body sites of infected or healthy individuals...Flags are inserted on a patient's...medical record by Infection Prevention...in the following situations: patient has a history of MDRO (multi drug resistant organisms)...laboratory results indicate current MDRO infection or colonization; physician indicates that the patient may have current MDRO infection or colonization...gowns and gloves must be worn by...staff and medical personnel upon every entrance into the patient room...Hand Hygiene must be performed by all persons prior to entering and upon leaving the patient room, in addition to appropriate moments during contact with the patient and/or the patient's surroundings...</p> <p>On 4/24/15 at 9:49 a.m. the DON (Director of Nursing) provided a copy of the pharmacy "Returns and Wastes"</p>			

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	<p>dated 4/23/15 for Resident #63. This form indicated the following: On 4/23/15 at 8:41 and 8:42 a.m., LPN #7 had returned 2 pills and 1 nebulizer treatment to the Pyxis system. These medications were returned after LPN #7 had been in the Resident's #63's isolation room.</p> <p>On 4/24/15 at 9:50 a.m. Pharmacy Technician (tech) #9 was interviewed. She indicated after pills are placed into the "return internal bin" locked inside the top drawer of the Pyxis machine by the nurse, the pharmacy techs come to the medication room. The Pharmacy Tech indicated if there was no discrepancy, the Pharmacy Tech returns the pills to the Pyxis machine on the unit for reticulation.</p> <p>On 4/24/15 at 10 a.m. the DON (Director of Nursing) was interviewed. She was made aware LPN #7 was observed to take her nursing clipboard, pen, stethoscope and prepackaged medications into Resident #63's contact isolation room. The DON was also made aware LPN #7 took medications out of the isolation room, placed them back into the Pyxis machine for reticulation and exited the contact isolation room without having cleaned the clipboard, pen, stethoscope and/or mobile vital sign machine (until</p>			

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	<p>she reached the nursing station). The DON was also made aware LPN #7 returned 2 unused medications into the Pyxis machine after handling them with gloves used during the medication administration and/or touching the resident's soiled elbow inside the isolation room. The DON indicated if reusable equipment is used in an isolation room, it should be wiped down and sanitized prior to leaving the room. She indicated staff were to keep a stethoscope in the resident's isolation room for use. She indicated the nurse should not have taken her clipboard and pen into the isolation room. She also indicated the nurse should not have brought the prepackaged medications out of the isolation room and placed back into the Pyxis machine for reticulation.</p> <p>C.1. An observation of Occupational Therapist (OTR) #3 on 4-21-2015 at 10:50 a.m., indicated the following: OTR #3 walked with Resident #218 to his room and entered the room without the use of hand sanitizer, gloves or a yellow gown. Resident #218's room door had a sign on the door which indicated "...Contact Precautions...." Further observation of Resident #218's door indicated a sign that had "stop" printed in large letters "...Contact</p>			
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	<p>Precautions please wear the following..." with a picture of gloves and a gown. An observation of the over the door caddy indicated no yellow gowns were present.</p> <p>The OTR #3 was observed to return from Resident #218's bedside to the door and don gloves and walk back to Resident #218's bedside.</p> <p>The OTR #3 returned to the doorway, removed her gloves, used hand sanitizer and left the room.</p> <p>The OTR #3 was observed to return 5 minutes later and without use of the hand sanitizer, donned gloves and the yellow gown and entered the room to assist Resident #218.</p> <p>An interview with the ADON (Assistant Director of Nursing) on 4-22-2015 at 11:40 a.m., indicated Resident #63 had contact precautions for a history of MRSA (Methacillin Resistant Staphylococcus Aureus) and Resident #218 had contact precautions for Clostridium Difficile.</p> <p>A review of Resident #218's record began on 4-24-2015 at 11:55 a.m., indicated diagnoses included but were not limited to acute monocytic leukemia, chronic back pain and Clostridium difficile colitis.</p>			

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	<p>A review of laboratory results dated 4-14-2015 at 4:48 a.m., indicated Resident #218 was positive for toxigenic Clostridium difficile.</p> <p>A review of physician orders dated 4-14-2015 at 7:26 a.m., indicated Resident #218 was on contact isolation status.</p> <p>A review of the Protective Precautions care plan dated 4-2-2015 indicated the following interventions: wear isolation gown and gloves upon every entrance to the patient room. utilize isolation/special precautions as indicated...contact precautions for C-Diff (Clostridium difficile).</p> <p>C.2. An observation on 4-22-2015 at 1:28 p.m. indicated Resident #63's room had a contact isolation sign posted on the door. Further observation indicated RN #4 came to the doorway from Resident #63's bedside without wearing a yellow gown. RN #4 was observed to don a yellow gown and return to the resident's bedside.</p> <p>A review of Resident #63's record began on 4-24-2015 at 10:20 a.m., indicated diagnoses included but were not limited to asthma, COPD (chronic obstructive pulmonary disease, diabetes, diabetes,</p>			

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	<p>traumatic ulcer of lower leg and a history of MRSA carrier in the nares.</p> <p>A review of the physician orders provided by the ADON on 4-24-215 at 10:20 a.m., indicated a contact isolation status was ordered on 4-10-2015 at 4:57 p.m.</p> <p>An interview with RN #2 on 4-23-2015 at 2:45 p.m., indicated for residents with contact precautions, staff should have donned gloves and a yellow gown before entering the resident's room. Further interview with RN #2 indicated portable equipment taken into a contact isolation room should have been cleaned with the Sani wipes at the doorway entrance of the room and before taking the equipment out of the room.</p> <p>An interview with the Administrator and DON (Director of Nursing) on 4-23-2015 at 4:25 p.m., indicated equipment taken into a resident room who was identified on isolation should not be cleaned at the nurse's station. The Administrator and DON indicated the equipment should be cleaned just outside the isolation room door. Further interview with the Administrator and the DON indicated the isolation over the door caddies were stocked with the standard gloves, yellow gown and masks and it would be</p>			

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	<p>expected for staff to wear all the equipment including the mask during a breathing treatment if a resident had the infection identified in the respiratory tract.</p> <p>A copy of the "...Contact Precaution" sign dated 2-08 and provided by the ADON on 4-24-2015 at 9:25 a.m., indicated "...use hand sanitizer before putting gloves on and after removing gloves...wear gloves when entering room -- remove gloves before leaving patient room...wear gown when entering a patient room if you anticipate contact with patient or environment -- remove gown before leaving room...common conditions requiring contact precautions...Clostridium difficile associated diarrhea...Multi-Drug Resistant Organisms...MRSA...."</p> <p>A current policy "Cleaning Responsibilities" dated 03/2014 and provided by the ADON on 4-23-2015 at 3:30 p.m., indicated "...items to be cleaned...mobile...carts...if used in an isolation room...before leaving isolation room and immediately after leaving room...."</p> <p>A current policy "Clostridium Difficile and or Unexplained Diarrhea" dated 12/2011 and provided by the ADON on</p>			

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	<p>4-22-2015 at 11:22 a.m., indicated "...contact precautions will include...gowns and gloves readily available...hand hygiene should be strictly enforced...all hospital staff and medical personnel will utilize alcohol based hand sanitizer for routine hand hygiene...patient care equipment should be dedicated to the patient whenever possible...if the use of common equipment or items is unavoidable, they must be thoroughly cleaned prior to removal from the patient room and before use with another patient...the chart should not be carried into the patient room...."</p> <p>D. An observation of a dressing change for Resident #221 by RN #5 on 4-23-2015 at 2:05 p.m., indicated the following: RN #5 was observed to have gathered supplies and used the Sani wipes to clean the overbed table in the resident's room. RN #5 was observed to have washed hands, donned gloves and removed the dressing from Resident #221's right groin area. Without changing gloves, RN #5 was observed to have cleaned Resident #221's right groin area with two 4 x 4 fluffs dampened with normal saline and dried with a clean 4 x 4 fluff. RN #5 was observed to have removed her gloves, washed her hands and prepared</p>			

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	<p>the dressing supplies on a sterile area (an applicator, packaged scissors, 2 ABDs and a container of kerlix with Hegger's solution poured on the kerlix.)</p> <p>RN #5 was observed to don sterile gloves, apply the dampened kerlix to the wound area, cover the kerlix with two ABDs and secure the dressing with tape and a pair of stretchy briefs.</p> <p>RN #5 was observed to have removed her gloves, gathered the trash in a bag, moved the overbed table and repositioned Resident #221's drinking cup.</p> <p>RN #5 was observed to have carried the trash to soiled utility room, placed it in a red container and on the way out of the soiled utility room the RN #5 used the hand foam sanitizer to clean her hands.</p> <p>An interview with LPN #6 on 4-23-2015 at 3:55 p.m., indicated for a dressing change she would have done the following:</p> <p>washed her hands prior to the procedure  donned gloves  removed the old dressing  removed her gloves  discarded the gloves  donned clean gloves  cleaned the wound  removed her gloves  donned clean gloves  applied the dressing  cleaned up the area with bleach wipes</p>			

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	<p>gathered the trash discarded the gloves washed her hands prior to leaving the resident room.</p> <p>A review of Resident #221's medical record provided by the ADON on 4-24-2015 at 10:20 a.m., indicated diagnoses included but were not limited to bacteremia, cellulitis, uncontrolled type II diabetes, hypertension and history of necrotizing fasciitis (flesh eating bacteria).</p> <p>A review of Resident #221's physician orders for the dressing change dated 4-23-2015 indicated the following: "dry peri wound skin prior to each dressing application...protect skin with Cavilon spray prior to replacing dressing...use minimal layers of kerlix to affected area of Hegger's wet to dry dressing change every 8 hours...minimal or no tape to cover dressing...use disposable brief to hold in place...."</p> <p>A current policy "Dressing Changes" dated 03/2014 and provided by the ADON on 4-23-2015 at 3:30 p.m., indicated "...apply clean gloves...remove tape, bandages, or ties...remove dressing...fold dressing...remove gloves inside out...over the dressing...discard gloves and soiled dressing...perform hand</p>			

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F 999  Bldg. 00	<p>hygiene...apply clean gloves...cleanse wound...remove gloves and perform hand hygiene...apply sterile gloves...secure dressing...discard used supplies, remove personal protective equipment and perform hand hygiene...."</p> <p>3.1-18(b)(2) 3.1-18(l)</p> <p>Based on interview and record review, the facility failed to ensure staff employed on the unit completed dementia training for 3 of 10 employee records reviewed. (Speech Language Pathologist SLP #10, Housekeeping #11 and Dietitian #12)</p> <p>Findings include:</p> <p>A review of the employee records on 4-23-2015 at 11:00 a.m., indicated SLP #10 with a start date of 6-3-2013, Housekeeping #11 with a start date of 6-23-2013 and Dietitian #12 with a start date of 4-9-2014 had no evidence of completing any dementia training.</p> <p>An interview with the DON (Director of Nursing) on 4-23-2015 at 1:15 p.m.,</p>	F 999	<p>1. The three contracted staff noted in survey results will attend six hour Dementia Training during below scheduled dates.2. Contracted staff from Housekeeping, Dietary, and Pharmacy will attend Six Hour Dementia Training offered on May 14, 2015 and May 19, 2015. Therapy Department staff will attend two hours of Dementia Training the weeks of May 4, May 11 and May 18, 2015, for a total the six hours of training.3. All newly hired contracted staff will attend six hour Dementia Training within six months of employment.4. Yearly thereafter, all contracted staff will attend three hour Dementia Training offered by the Continuing Care Center Educator and/or designee. 5. Contracted employee files will be reviewed quarterly by Director of Nursing</p>	05/24/2015
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	<p>indicated SLP #10, Housekeeping #11 and Dietitian #12 were contracted by the facility and the facility did not check to see if the contracted staff had the 6 hours of initial dementia training or the annual 3 hours of dementia training completed.</p> <p>An interview with the DON on 4-23-2015 at 1:30 p.m., indicated after checking with the contracting companies, it was determined the 3 staff (SLP #10, Housekeeping #11 and Dietitian #12) did not complete any dementia training provided by the contracted companies.</p> <p>A review of the of the Resident Census and Conditions of Residents provided by the DON during the survey indicated 2 of the 33 residents had diagnoses of dementia or Alzheimer's disease.</p> <p>An interview with the Administrator and the DON on 4-23-2015 at 4:00 p.m., indicated it was not the facility's practice to check the contracted staff (therapy staff, housekeeping staff and the Dietitian) for completion of dementia training.</p> <p>The Administrator indicated she was not aware of a personnel policy for the dementia training for the contracted facility staff.</p> <p>3.1-14(k)(6)</p>		and CCC Administrative Secretary to assure compliance with Dementia Training requirements.	

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