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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 01/14/2015 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 8, 9, 12, 13, and 14, 2015</p> <p>Facility number: 000559 Provider number: 155719 AIM number: 100267170</p> <p>Survey team: Caitlyn Doyle, RN-TC Heather Hite, RN Julie Ferguson, RN Jennifer Redlin, RN (January 12, 13, and 14, 2015)</p> <p>Census bed type: SNF: 2 SNF/NF: 59 Total: 61</p> <p>Census payor type: Medicare: 5 Medicaid: 30 Other: 26 Total: 61</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> | F000000 | <p>January 30, 2015 Miriam Buffington Enforcement Manager Long Term Care Division Indiana State Department of Health 2 North Meridian Section 4-B Indianapolis, IN 46204-3006 Re: Survey ID LYCZ11 HealthSurvey Dear: Miriam Buffington This letter is in regards to the aforementioned survey that was conducted on January 14, 2015. The following plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 13th day of February, 2015. At this time we are respectfully requesting a desk review for paper compliance, to clear the findings and stop any and all proposed or implemented remedies that have been presented to date. If you have questions or need further information, please call 219-275-2531 or fax 219-275-7472. I can also be reached via email at admin@georgeade.org. Thank you, Scott James, HFA February 3, 2015 Janelyn Kulik, RN Surveyor Supervisor Long Term Care Division Indiana State Department of Health Facility #: 000559 Provider #: 155719 Survey Event ID: LYCZ11 Survey Date: January 14, 2015</p> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| F000223 SS=D | <p>Quality review completed on January 21, 2015, by Janelyn Kulik,RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from abuse related to a substantiated allegation of physical and verbal abuse for 1 of 3 abuse allegations reviewed and 1 of 3 residents reviewed for abuse. (Resident #54)</p> <p>Finding includes:</p> <p>The closed record for Resident #54 was reviewed on 1/13/15 at 3:38 p.m. The</p> | F000223 | <p>The following information is in response to the request from your office regarding the POC for George Ade Memorial Health Care Center, Brook, IN. Please include this information with the previous response provided.</p> <p>If there are any questions on further information, please contact W.R. Scott James, HFA at admin@georgeade.org.</p> <p>Thank you. W.R. Scott James, HFA</p> <p>F223 It is the practice of this facility to provide an abuse free environment and to promote this ongoing to each staff member. Appropriate actions were taken upon being made aware of the abuse allegation; those include suspension, investigation and follow through. Allegations are investigated with actions taken to protect the resident/residents involved so as to prevent further allegations. As outlined in the facility abuse protocol policy, allegations are reported,</p> | 02/13/2015 |

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| | <p>resident's diagnoses included, but were not limited to, dementia with depression, episodic mood disorder, and hypertension.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment, dated 10/1/14, indicated the resident was cognitively impaired.</p> <p>Review of an incident investigation dated 11/13/14 at 7:00 p.m., indicated LPN #2 slapped the hand of Resident #54 and spoke of flipping him out of his wheelchair on 11/13/14 at 6:20 p.m. Dietary Aide #1 called the Administrator to report the incident on 11/13/14 at 7:00 p.m. The Director of Nursing (DON) arrived to the facility on 11/13/14 at 7:20 p.m. and removed LPN #2 from the floor.</p> <p>The immediate action taken included LPN #2 was suspended pending results of the investigation.</p> <p>Upon further investigation by the facility it was found LPN #3 had been involved in the incident and had used obscene language toward Resident #54.</p> <p>On 11/14/14 LPN #3 was issued an employee warning notice. The warning notice indicated it was a first warning and LPN #3 was not to use obscene language</p> | | <p>investigated with follow through to resolve the situation. -See Attached- Staff will be provided in-service materials to assure proper procedures are followed. The in-service will be provided on 01/29/2015 for allstaff. -See Attached- Random audits for abuse procedures will be conducted weekly for two weeks, then randomly conducted one to two times for an additional two weeks for review in QA. This will continue until a 95% standard is met. This will be completely by 02/13/2015 with ongoing audits. Administrator and QA committee will be responsible to follow up for compliance.</p> <p>Addendum Yes, resident was assessed following the report incident(see attached resident #54 progress note) as per normal procedure an investigation was conducted which included speaking with other residents in the given service area. There were no indicators of any other abuse activity. (see attached) As reflected in the facility abuse policy the Administrator was notified immediately with appropriate actions taken to assure the safety of the residents.</p> | | | | |

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| F000225 SS=D | <p>in front of residents. The warning indicated any further profanity would be met with disciplinary action.</p> <p>Based on the findings of the facility's investigation, "LPN #2 did handle Resident #54 in a rough manner and did verbally intimidate resident." The allegation of abuse was substantiated and LPN #2 was terminated 11/14/14.</p> <p>Interview with the Administrator on 1/12/15 at 2:29 p.m., indicated the abuse allegation had been substantiated and LPN #2 had been terminated. He further indicated it was found during the investigation that LPN #3 had used inappropriate language and once he was made aware LPN #3 had been issued a warning. He further indicated shortly following the incident LPN #3 chose to resign and no longer worked at the facility.</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered</p> | | | | | | |

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| | <p>into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse and failed to notify the Indiana State Department of Health (ISDH) of an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident #26)</p> | F000225 | It is the practice of this facility to hire only staff that has no known evidence of abuse or alleged abuse. This incident was brought up following questions as part of the QIS process. Upon discussion of the incident with the surveyor who was present, it was | 01/29/2015 | |

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| | <p>Finding includes:</p> <p>During an interview on 1/8/15 at 10:43 a.m., Resident #25 indicated she had witnessed another resident being abused. She indicated she had witnessed Resident #26 crying because he didn't want to go in his room. She indicated Resident #26 had refused to go in his room and staff had forced him to go in. She further indicated she reported the incident to staff but was unsure who she had told. She indicated she was unsure how long ago the incident happened but it was "a while ago."</p> <p>The record for Resident #25 was reviewed on 1/12/15 at 10:34 a.m. The resident's diagnoses included, but were not limited to, hypertension and type II diabetes mellitus.</p> <p>The resident's Quarterly Minimum Data Set (MDS) assessment, dated 11/20/14, indicated the resident was cognitively intact.</p> <p>The record for Resident #26 was reviewed on 1/12/15 at 9:15 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, dementia with depression, and episodic mood disorder.</p> | | <p>felt that there had been an informed notification to the department of health in regards to this. The facility regularly reports allegations when aware of them. Upon doing so, an investigation was conducted. The investigation showed no abuse was substantiated and this also was relayed to the surveyor at the time we were made aware. The facility has a policy/protocol that is followed when allegations are presented. Staff will be in-serviced on abuse policy on 01/29/2015. Random audits for abuse procedures will be conducted weekly for two weeks, then randomly conducted one to two times for an additional two weeks for review in QA and will continue until the 95% standard is met. Administrator and QA committee will be responsible to followup for compliance.</p> <p>Addendum</p> <p>Resident #26 and #25 were interviewed and there was nonoted incidents recalled by the resident as cited (see attached). There were no other residents indicated as per the information provided.</p> <p>Staff have been in-serviced on abuse policy and the appropriate measures to be taken. See attached In-service sign in sheet for abuse in-service.</p> | | | | |

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| | <p>The resident's Quarterly MDS assessment, dated 11/13/14, indicated the resident was cognitively impaired.</p> <p>Review of the facility's reported abuse allegations from March 2014 through January 2015 indicated a lack of documentation that the incident had been reported or investigated.</p> <p>Interview with the Administrator on 1/12/15 at 2:45 p.m. indicated he was unaware of any abuse allegations from Resident #25 regarding Resident #26. He further indicated Resident #26 had recently lost his wife and had episodes of tearfulness at times. He indicated he would talk to social services and see if she was aware of any reported allegations.</p> <p>Interview with the Administrator on 1/14/15 at 9:33 a.m. indicated he had talked to social services about the situation, but the concern was not officially reported to ISDH or treated as an official abuse allegation. He further indicated, social services was unaware of any reports of abuse. He indicated, based on Resident #26's history of behaviors and the information reported being second and third hand, he felt the situation was not abuse and nothing</p> | | | | | | |

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| F000226 SS=D | <p>could be substantiated if he had done a full investigation.</p> <p>3.1-28(c) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow the facility's abuse policy related to thoroughly investigating an allegation of abuse and notifying the Indiana State Department of Health (ISDH) of an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident #26)</p> <p>Finding includes:</p> <p>During an interview on 1/8/15 at 10:43 a.m., Resident #25 indicated she had witnessed another resident being abused. She indicated she had witnessed Resident #26 crying because he didn't want to go in his room. She indicated Resident #26 had refused to go in his room and staff had forced him to go in. She further indicated she reported the incident to</p> | F000226 | <p>It is the practice of this facility to maintain and implement written policy and prohibit the mistreatment, neglect and abuse of our residents and or their property. This incident was brought up following questions as part of the QIS process. Upon discussion of the incident with the surveyor who was present, it was felt that there had been an informed notification to the department of health in regards to this. The facility regularly reports allegations when aware of them. Upon doing so, an investigation was conducted. The investigation showed no abuse was substantiated and this also was relayed to the surveyor at the time we were made aware. The facility has a policy/protocol that is followed when allegations are presented. Staff will be in-serviced on abuse policy on</p> | 01/29/2015 | | | |

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| | <p>staff but was unsure who she had told. She indicated she was unsure how long ago the incident happened but it was "a while ago."</p> <p>The record for Resident #25 was reviewed on 1/12/15 at 10:34 a.m. The resident's diagnoses included, but were not limited to, hypertension and type II diabetes mellitus.</p> <p>The resident's Quarterly Minimum Data Set (MDS) assessment, dated 11/20/14, indicated the resident was cognitively intact.</p> <p>The record for Resident #26 was reviewed on 1/12/15 at 9:15 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, dementia with depression, and episodic mood disorder.</p> <p>The resident's Quarterly MDS assessment, dated 11/13/14, indicated the resident was cognitively impaired.</p> <p>Review of the facility's reported abuse allegations from March 2014 through January 2015 indicated a lack of documentation that the incident had been reported or investigated.</p> <p>Interview with the Administrator on</p> | | <p>01/29/2015. Random audits for abuse procedures will be conducted weekly for two weeks, then randomly conducted one to two times for an additional two weeks for review inQA and will continue until the 95% standard is met. Administrator and QA committee will be responsible to followup for compliance.</p> <p>Addendum Resident #26 and #25 were interviewed and there was nonoted incidents recalled by the resident as cited (see attached). There were no other residents indicated asper the information provided. Staff have been in-serviced on abuse policy and the appropriatemeasures to be taken. See attached In-servicesign in sheet for abuse in-service.</p> | | | | |

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| | <p>1/12/15 at 2:45 p.m. indicated he was unaware of any abuse allegations from Resident #25 regarding Resident #26. He further indicated Resident #26 had recently lost his wife and had episodes of tearfulness at times. He indicated he would talk to social services and see if she was aware of any reported allegations.</p> <p>Interview with the Administrator on 1/14/15 at 9:33 a.m. indicated he had talked to social services about the situation, but the concern was not officially reported to ISDH or treated as an official abuse allegation. He further indicated, social services was unaware of any reports of abuse. He indicated, based on Resident #26's history of behaviors and the information reported being second and third hand, he felt the situation was not abuse and nothing could be substantiated if he had done a full investigation.</p> <p>A facility policy titled "Resident Abuse", dated 2/13/13, and received as current from the Administrator, indicated "...Reporting:...C. The Administrator or his/her designee will notify the following persons immediately, by phone and in writing, of the alleged mistreatment, neglect, or abuse: 1. State Licensing and Certification Agency;</p> | | | | | | |

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| F000246 SS=D | <p>ISDH...Investigation: A. The Administrator and/or his/her designee will investigate reports of mistreatment, neglect, or abuse immediately upon notification..."</p> <p>3.1-28(d) 3.1-28(e)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure a a resident had access to the call system for 1 of 35 residents observed during Stage 1. (Resident #21)</p> <p>Finding includes:</p> <p>During initial tour on 1/8/15 at 10:43 a.m., Resident #21's call light was on the floor. After the resident was given the call light, the resident was not able to push the red button on the call light.</p> <p>During an observation on 1/9/15 at 10:44 a.m., the resident was asleep in his</p> | F000246 | <p>It is the practice of this facility to provide services to the residents of the facility that accommodate individual needs and preferences. This is done unless the health or safety of the resident is endangered by such practice. All residents will be reviewed for call light tap bell or bell system in reach. All residents have potential for call light being out of reach. Resident 21 OT screen provided to ensure ability and correct call light placement, see attached. All nursing staff to be educated on call light placement. Random audits to occur two to three times for four weeks then if 95% compliance further review decision made by the QA team. No actual</p> | 01/29/2015 |

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| | <p>wheelchair with the call light on the floor.</p> <p>On 1/9/15 at 1:38 p.m., the resident was watching TV in his wheelchair and his call light was on his pillow on his bed. Interview with LPN #1 at that time indicated the resident was able to use the call light. LPN #1 handed the resident the call light and the resident demonstrated that he was unable to push the red button on the call light. LPN #1 then indicated the resident uses a "tap bell," which could not be located by CNA #1 nor LPN #1.</p> <p>Resident #21's record was reviewed on 1/12/15 at 8:50 a.m. The resident's diagnoses included, but were not limited to, anxiety, hemiplegia nondominant side, and dementia.</p> <p>The Annual MDS (Minimum Data Set) assessment on 11/6/14 indicated the resident was cognitively intact. For transfers, the resident was totally dependant with assist or two staff members and was an extensive assist with two staff members for toileting. The resident's functional limitations indicated impairment to one side of his upper and lower extremities (arm and leg).</p> <p>3.1-3(v)(1)</p> | | <p>harm to the resident wasnoted. DON or designee to be responsible for audits.</p> <p>This is completed as of01/29/2015.</p> | | | | |

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| F000279 SS=D | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan for a resident with a current respiratory condition requiring a scheduled breathing treatment for 1 of 1 residents observed for breathing treatment administration of the 7 residents observed during medication pass observations. (Resident #15)</p> <p>Finding includes:</p> | F000279 | It is the practice of this facility to assess and develop comprehensive care plans for each resident as needed so as to practice appropriate care for them. It is the Policy of this facility to develop care plans for resident with respiratory conditions requiring a breathing treatments administration. Resident#15 care plan was reviewed and a respiratory care plan was developed. See attached. MDS nurse received | 01/29/2015 |

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| | <p>The record for Resident #15 was reviewed on 1/12/15 2:00 p.m. Diagnoses included, but were not limited to, symptom cough.</p> <p>Review of the Physician's Order dated 11/20/14 indicated Ipratropium-albuterol (a medication for breathing treatment) solution for nebulizer four times a day for symptom cough.</p> <p>Review of the 1/2015 MAR (Medication Administration Record) indicated the breathing treatment was given four times a day as ordered.</p> <p>The record lacked a current care plan for the resident's respiratory condition.</p> <p>Interview on 1/12/15 at 2:14 p.m., the MDS Coordinator indicated there was not a respiratory care plan and one should have been created for Resident #15.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> | | <p>education related to the need to develop comprehensive care plan. All residents with respiratory treatments had care plans reviewed. Audits to residents with respiratory treatments to have care plans reviewed by MDS nurse or designee two to three times for one week then, once a week for four weeks. If 95% compliance, further review to QA committee. -See Attached-</p> | | | | |

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| F000315 SS=D | <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with a urinary catheter received the necessary treatment and services to prevent urinary tract infections for 1 of 3 residents reviewed for urinary catheters of the 3 who met the criteria for urinary catheter use. (Resident #70).</p> <p>Finding includes:</p> | F000315 | <p>It is the practice of this facility to assess each resident for their care needs. The use of catheters is used only when medically necessary and under a physician's orders. It is the policy of GAHCC to ensure the residents with urinary catheter receive the necessary treatment to prevent infection. Resident #70 catheter tubing was adjusted to prevent touching the floor until it was discontinued. No actual harm or signs of infections were</p> | 01/29/2015 |

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| | <p>On 1/8/15 at 12:11 p.m., Resident #70 was observed sitting in the main dining room for lunch with the Foley urinary catheter tubing on the floor under the wheelchair.</p> <p>On 1/8/15 at 1:46 p.m., the resident was observed in her room with the Foley urinary catheter tubing on the floor under the wheelchair.</p> <p>Resident #70's record was reviewed on 1/12/15 at 10:50 a.m. Diagnoses included, but were not limited to, urinary retention due to excessive fluid.</p> <p>The current Physician's Order Summary indicated Foley catheter X 7 days, catheter care every shift.</p> <p>A Care Plan dated 1/7/15 indicated indwelling urinary catheter with the approach do not allow tubing or any part of the drainage system to touch the floor.</p> <p>Interview with the DON (Director of Nursing) on 1/12/15 at 2:34 p.m., indicated the Foley urinary catheter tubing should not have been on the floor.</p> <p>3.1-41(a)(2)</p> | | <p>incurred by resident #70. All residents with unary catheter have the potential to be at risk for tubing to touch the floor. All resident with Foley catheter were reviewed Nursing staff educated on proper positioning of Foley catheter tubing Auditing of all residents with catheter tubing to be done two to three times for one week then once a week for four weeks until compliance of 95% achieved, further review and determination to be made by the QA committee. DON or designee to be responsible for audits. This is completed as of 01/29/2015. -See Attached-</p> | |

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| F000328 SS=D | <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to assess a resident before and after a breathing treatment for 1 of 1 residents observed for breathing treatment administration of the 7 residents observed during medication pass observations. (Resident #15)</p> <p>Finding includes:</p> <p>During a medication pass observed on 1/12/15 from 11:09 a.m. until 11:19 a.m., LPN #4 administered a breathing treatment to Resident #15 as ordered.</p> | F000328 | It is the practice of this facility to ensure that our residents receive proper treatments and care for special services. It is the policy of GAMHCC to provide standard nursing care when administering small volume nebulizer. Resident #15 record was reviewed for orders related to breathing treatment administration, All licensed nursing staff were in-service don the administration of nebulizer therapy according to Lippincot Manual of Nursing Practice Copy Right 2010; Wolster and Wilkins. No actual harm occurred to resident. The EMAR was changed to reflect the statement to check pulse and lung | 01/29/2015 | |

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| | <p>When the treatment was completed, LPN #4 cleaned and replaced the equipment and left the room. LPN #4 did not assess the resident prior to the breathing treatment or after the treatment was completed. Interview with LPN #4 at that time indicated that she assessed the resident's lung fields this morning when she came on shift. She further indicated that she did not assess the resident's lung fields before or after breathing treatments.</p> <p>Interview with the DON (Director of Nursing) on 1/12/15 at 11:30 a.m. indicated there was not a specific policy on breathing treatments. She indicated the nurses should follow the Lippincott Manual of Nursing for the procedure. The DON further indicated the nurse should have assessed the resident before and after a breathing treatment.</p> <p>The record for Resident #15 was reviewed on 1/12/15 at 2:00 p.m. Diagnoses included, but were not limited to, symptom cough.</p> <p>Review of the Physician's Order dated 11/20/14 indicated Ipratropium-albuterol (a medication for breathing treatment) solution for nebulizer four times a day for symptom cough.</p> | | <p>sounds before and after respiratory treatment and allow documentation. All residents who receive small volume nebulizer therapy will have orders reviewed and updated on EMAR to include the documentation of pulse and lung sounds before and after breathing treatments. Policy related to small volume nebulizer reviewed and updated. Nurses educated related to assessment and documentation of lung sounds and pulse before and after respiratory treatments. Auditing of small volume nebulizer orders to be done two to three times for one week then, once a week for four weeks. If 95% compliance achieved, further auditing to be determined by the QA committee. DON or designee to be responsible for audits. This is completed as of 01/29/2015. -See Attached-Addendum</p> <p>It is the policy of GAMHCC to provide standard nursing care when administering small volume nebulizer. Resident #15 record was reviewed for orders related to breathing treatment administration. All licensed nursing staff were in-serviced on the administration of nebulizer therapy according to Lippincott Manual of Nursing Practice Copy Right 2010; Wolster and Wilkins. Resident #15 lung sounds and pulse assessed per guidelines from Lippincott Manual of Nursing Practice CopyRight 2010,</p> | | | | |

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| F000431 SS=E | <p>Review of the 1/2015 MAR (Medication Administration Record) indicated the breathing treatment was given four times a day as ordered.</p> <p>On 1/12/15 at 11:52 a.m., the DON provided The Lippincott Manual of Nursing Practice, 9th edition, copy right 2010, Procedure guidelines for administering nebulizer therapy which included the preparatory, performance and follow-up phases. The "Preparatory phase 1. Auscultate breath sounds, monitor the heart rate before and after the treatment for patients using bronchodilator drugs...."</p> <p>3.1-47(a)(6)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt</p> | | <p>with no adverse effects. Noactual harm occurred to resident. The EMAR was changed to reflect the statementto check pulse and lung sounds before and after respiratory treatment and allowdocumentation. All residents who receive small volume nebulizer therapy have hadorders reviewed and updated on EMAR to include the documentation of pulse andlung sounds before and after breathing treatments. Policy related to smallvolume nebulizer reviewed and updated. Nurses educated related to assessmentand documentation of lung sounds and pulse before and after respiratorytreatments. Auditing of small volume nebulizer orders to be done two to threetimes for one week then, once a week for four weeks. If 95% complianceachieved, further auditing to be determined by the QA committee.</p> | | | | |

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| | <p>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 properly store medications in a refrigerator for 1 of 3 refrigerators observed and a resident's breathing treatments in a medication cart for 1 of 3 medication carts observed. (Conference Room refrigerator and Elm Court Medication Cart)</p> | F000431 | It is the practice of this facility to retain the services of a licensed pharmacist, and follow applicable regulations. State and federal laws as applied to long term care facilities. It is the policy of GAMHCC to store drugs and biological in accordance with currently accepted professional principles and manufacturers or suppliers recommendation. The | 01/29/2015 | |

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| | <p>Finding includes:</p> <ol style="list-style-type: none"> 1. On 1/8/15 at 9:27 a.m., the following was observed in the Conference Room refrigerator with no thermometer and with food: <ol style="list-style-type: none"> a. Three injectable pre-filled syringes of Influenza Vaccines. b. One vial of Hepatitis B vaccine. c. One vial of Tubersol opened and dated 12/4/14. <p>Interview with DON (Director of Nursing) on 1/8/15 at 9:34 a.m., indicated the medications should not have been stored in that refrigerator.</p> <p>The facility policy on "Medication Storage in the Facility," was received as current by the DON on 1/9/15 at 11:25 a.m., indicated "...Procedures...K. Medications requiring "refrigeration" or "temperatures between 2 degrees C (Celsius)... and 8 degrees C..." are kept in a refrigerator with a thermometer to allow temperature monitoring...L. Refrigerated medications are kept...Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator.</p> | | <p>improperly stored medication/biological in the conference room refrigerator was immediately disposed of. Nursing unit refrigerators in the facility were audited. The staff member responsible for storing the medications was provided education and in-serviced on proper storage. All nursing staff provided with updated addendum related to medication storage. Improperly stored Ipratropium/albuterol solutions are to be stored according to manufacturers' recommendation and vials were disposed of. Nursing staff education and in-serviced regarding storage. Update addendum provided to staff. Auditing of med carts and refrigerator to be done two to three times for one week then, once a week for four weeks until compliance of 95% achieved. Further review to be determined by QA committee. DON or designee to be responsible for audits. This is completed as of 01/29/2015. -See Attached-</p> | |

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| | <p>2. On 1/13/15 at 11:00 a.m., the following was observed on the Elm Court medication cart:</p> <p>a. Three loose Ipratropium Albuterol solution vials in the box, not in a foil package.</p> <p>Interview with LPN #4 at that time indicated the medication should have been in a foiled package with an open date.</p> <p>A copy of the Ipratropium Bromide and Albuterol Sulfate box was provided by the DON on 1/13/15 at 2:17 p.m. and she indicated the facility did not have a specific policy on storage for breathing treatments. She indicated the nurse's should follow the storage indications on the box, to which indicated, "...store in pouch until time of use...."</p> <p>3.1-25(j) 3.1-25(m)</p> | | | |

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| F000441 SS=E | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> | | | |
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| | <p>Based on observation, interview, and record review, the facility failed to follow standard cleaning precautions during the performance of routine testing of blood glucose levels, related to disinfecting a blood glucose monitor (checks blood sugars) after usage from one resident to another resident. This had the potential to affect 1 of 3 residents who required blood glucose monitoring using the Main Street #2 blood glucose monitoring machine. (Main Street Medication Cart)</p> <p>The facility also failed to ensure infection control was maintained related to clean linen cart not covered in the Main Street Hallway, a resident's oxygen tubing not properly stored and no a sign for a resident in contact isolation. (Main Street Hallway, Resident #20 and Resident #87)</p> <p>Findings include:</p> <p>1. On the MS2 (Main Street #2 Medication Cart) the following was observed:</p> <p>On 1/12/15 at 3:51 p.m., LPN #5 was observed to have properly performed a blood glucose test on a resident, then place the glucometer on the MS2 cart on a paper towel to clean the monitor. LPN #5 removed a wipe from the Clorox container, wiped down the monitor and let the monitor sit until 4:18 p.m. for the</p> | F000441 | <p>It is the policy of GAMHCC to ensure infection control is maintained related to oxygen tubing properly stored. It is the policy of GAMHCC to follow CDC guidelines related to posting signs of residents in contractisolation. It is the policy of GAMHCC to sanitize blood glucose monitors and follow universal precautions. Infection control has the potential to affect all residents at GAMHCC. Blood Glucometers have the potential to affect all residents receiving fingersticks. Policy and manufacturer recommendations reviewed and updated. All nursing Staff who perform blood glucometers finger sticks educated on policy and manufactures recommendation for cleaning and sanitizing. Blood glucometers in service given with education related to policy, manufacture recommendations as well as nursing competency on all nursing staff that perform finger sticks. Audits on proper cleaning of glucometers to occur 2 to 3 times a week for 1week then 1 time a week for 4 weeks, when 95% compliance achieved, review and further determination of monitoring to be determined by the QA committee. DON or designee to be responsible for audits. It is the policy of GAMHCC to store oxygen tubing to prevent infection according to standard guidelines. All oxygen tubing stored incorrectly has the potential to affect all residents</p> | 01/29/2015 | | | |

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| | <p>next resident's blood glucose testing. There was no visible blood on the monitor. The Clorox wipes container indicated it was bleach free and did not disinfect any blood borne pathogens.</p> <p>Interview on 1/13/15 at 12:15 p.m. with the Administrator, indicated the wrong cleaning wipes were used at the time of the cleansing of the blood glucose monitor. The Super Sani-Cloth Germicidal Wipes should have been used on all medical equipment and the Clorox Wipes should have only been used on non medical things like counter tops, keyboards,etc.</p> <p>The facility policy titled "Cleaning and Disinfection Guidelines" was received as current from the DON on 1/13/15 at 10:00 a.m. and indicated "...Cleaning and disinfection can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe...."</p> <p>2. On Main Street Hallway the following was observed:</p> <p>a. During initial tour on 1/8/15 at 9:13 a.m., a linen cart with hanging clean clothes was uncovered as the clothes were distributed down the Main Street Hallway.</p> | | <p>whouse oxygen. Auditing of all residents using oxygen to ensure proper storage will occur two to three times for 1 week then once a week for 4 weeks. Upon 95%compliance, further review of monitoring to be determined by the QA committee. All Nursing staff educated on proper storage of oxygen tubing to prevent infections. DON or designee to be responsible for audits. Environmental Services staff was instructed as to proper distribution of clean hanging clothes for residents. In-service was conducted on 01/26/2015. -See Attached- It is the policy of GAMHCC to maintained proper signage to follow current contact isolation recommendation by CDC. Infection policy reviewed and updated. All residents with infections reviewed for need of contact isolation. All nursing staff updated and in-serviced on policy. Auditing of posting signs on residents in contact isolation to occur two to three times for one week, then once a week for 4 weeks. Upon 95% compliance QA committee to review for further monitoring and auditing. DON or designee to be responsible for audits. This is completed as of 01/29/2015. -See attached- Addendum Attached is the information sheet from PDI Super SaniCloth that states in 2 minutes HIV, HBV, HCV are killed. See Attached.</p> | | |

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| | <p>Interview with Environmental Services #1 on 1/8/15 at 9:18 a.m., indicated the clean laundry should have been covered.</p> <p>b. During initial tour on 1/8/15 at 9:30 a.m., Resident #87's oxygen tubing was hanging, uncovered on the back of the resident's wheelchair in the hallway outside the resident's room.</p> <p>On 1/8/15 at 3:41 p.m., the resident's uncovered, oxygen tubing was on the seat of his wheelchair, outside of his room.</p> <p>On 1/9/15 at 8:40 a.m., Resident's #87's oxygen tubing was hanging on the back of his wheelchair uncovered in the hallway outside of his room.</p> <p>Interview with the DON (Director of Nursing) on 1/12/15 at 3:04 p.m., indicated all oxygen tubing should be placed in a plastic bag when not in use.</p> <p>c. On 1/9/15 at 10:45 a.m., Resident #20's room lacked a sign for contact isolation. A box of masks and gloves were on the handrail outside the resident's door.</p> <p>Interview with LPN #6 at that time, indicated Resident #20 was on contact isolation and there was no sign on the</p> | | | |

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| | <p>door because she was not a risk to others.</p> <p>Interview with the DON (Director of Nursing) and the Administrator on 1/9/15 at 11:40 a.m., indicated all staff used Universal Precautions and did not see the need for use of a sign. She further indicated the resident did have MRSA (Methicillin Resistant Aureus) and was on contact isolation.</p> <p>During the infection control interview on 1/14/15 at 1:20 p.m. the DON, indicated when residents were in contact isolation, all department heads and housekeeping were notified and the resident received isolation bins and a sign was posted on the resident's door.</p> <p>Review of Resident #20's record on 1/14/15 at 2:50 p.m., indicated the throat culture result dated 1/3/15 indicated positive for MRSA.</p> <p>The facility policy titled "Universal Precautions Policy," was received as current from the DON on 1/9/15 at 11:25 a.m. and indicated "...Standards...6. This facility's Universal Precautions Policy also includes the following effective precautions:...k. <u>Signs</u>: a sign will be placed conspicuously on the door of the resident's room or if not kept closed on the door frame advising visitors and staff</p> | | | |

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| F000465 SS=E | <p>to check at the nurse's station before entering the room... Signs shall indicate the specific precautions to be used. contact, Droplet, Airborne...."</p> <p>3.1-18(a) 3.1-18(j) 3.1-19(g)(1)(2)(3) 3.1-18(k)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain an environment that was safe, clean, and in a state of good repair, related to marred/gouged walls, paint chipped and peeling from the walls and door frames, rusted/discolored bathroom faucets and handles, and corrosion on the pipes for 2 of 2 units throughout the facility. (Main Street Hall and Elm Court Hall)</p> <p>Findings include:</p> | F000465 | F465 It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the general public. The repairs, painting and replacement, of the bathroom fixtures has been addressed for the following rooms; 12-B, 15-B, 16-A, 16-B,17-B, 22-A, 22-B, 24-A, 24-B, 26-A, 27-A, 30-A, 30-B, 31-A, 32-B, 33-B, 34-A,34-B, and 36-A in the Main Street unit. The repairs, painting and replacement, of the bathroom fixtures has been addressed for the following rooms; 112-A, | 02/13/2015 | | | |

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| | <p>During the Environmental tour on 1/14/15 at 10:15 a.m., - 10:50 a.m., with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor, the following was observed:</p> <p>1. Main Street</p> <p>a. In room 12-B, the wall near the room door was marred and gouged. Two residents resided in the room.</p> <p>b. In room 15-B, paint on the side of the bathroom mirror was peeling and chipped. Two residents resided in the room.</p> <p>c. In room 16 A&B, the bathroom door frame had chipped paint. Two residents resided in the room.</p> <p>d. In room 17-B, the side of the closet near the bathroom had chipped wood, metal bars/levers on the floor beside the toilet had a green/white corrosion, and the bathroom door frame had chipped paint. Two residents resided in the room.</p> <p>e. In room 22 A&B, the bathroom door frame had chipped paint and the wall beside the room door was marred/gouged. Two residents resided in the room.</p> | | <p>114-A, 115-B, 117-A, 118-A, 118-B, and 120-B in the Elm Court Unit. The up keep and maintenance of the physical plant is ongoing and rooms are checked weekly and repairs made accordingly. Environmental staff will notify maintenance of any repairs/painting in need as part of their daily cleaning routine. The environmental supervisor and staff will be responsible to report needed repairs to maintenance for repair. Check list and or request slips will be used to inform maintenance of such repairs. Daily assignment sheets will be checked weekly for needed repairs. This will be a continuous process. Completed/Implemented as of 2/13/2015</p> | | |

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| | <p>f. In room 24 A&B, the bathroom door frame molding was missing on the bottom of the frame and the bathroom faucet and handles were rusted/discolored. Two residents resided in the room.</p> <p>g. In room 26-A, the bathroom door frame had chipped paint and the bathroom faucet handles were rusted/discolored. Two residents resided in the room.</p> <p>h. In room 27-A, the bathroom door frame had chipped paint. One resident resided in the room.</p> <p>i. In room 30 A&B, the bathroom faucet handles were rusted/discolored and the drain in the sink had a yellow stain. One resident resided in the room.</p> <p>j. In room 31-A, the bathroom door frame had chipped paint. Two residents resided in the room.</p> <p>k. In room 32-B, the bathroom door frame had chipped paint, the bathroom faucet and handles were rusted/discolored, and a towel was folded underneath the toilet with yellow discolorations on it. Two residents resided in the room.</p> | | | |

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| | <p>Interview during the tour with the Maintenance Supervisor indicated it looked like the toilet had a leak but no staff had informed him.</p> <p>l. In room 33-B, the bathroom door frame had chipped paint and the sink had a yellow discoloration by the drain. Two residents resided in the room.</p> <p>m. In room 34 A&B, the bathroom door frame had chipped paint, the bathroom faucet handles and drain in sink were rusted/discolored, and the metal bars on the floor next to the toilet had a green/white corrosion. Two residents resided in the room.</p> <p>n. In room 36-A, the bathroom door frame had chipped paint, the bathroom faucet handles and drain in sink were rusted/discolored, and the light in the bathroom was dim and flickering. One resident resided in the room.</p> <p>2. Elm Court</p> <p>a. In room 112-A, the bathroom door frame had chipped paint. Two residents resided in the room.</p> <p>b. In room 114-A, the bathroom door frame had chipped paint, and the bathroom faucet and handles were</p> | | | |

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| | <p>rusted/discolored. Two residents resided in the room.</p> <p>c. In room 115-B, the bathroom door frame had chipped paint, the bathroom faucet and handles were rusted/discolored, and tile was missing from the wall underneath the toilet paper holder. Two residents resided in the room.</p> <p>d. In room 117-A, the bathroom door frame had chipped paint. Two resident resided in the room.</p> <p>e. In room 118 A&B, the bathroom door frame had chipped paint and the bathroom faucet and handles were rusted/discolored. Two residents resided in the room.</p> <p>f. In room 120-B, the paint was chipped on the corner walls near the bathroom and the closet. Two residents resided in the room.</p> <p>Interview with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor at the time of the tour indicated all areas are in need of repair or cleaning.</p> <p>3.1-19(f)</p> | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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