

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2011
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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN46321
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 31, November 1, 2, 3, 4, and 7, 2011</p> <p>Facility number: 000056 Provider number: 155131 Aim number: 100289450</p> <p>Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Heather Tuttle, RN Janet Adams, RN</p> <p>Census bed type: SNF: 18 SNF/NF: 177 Total: 195</p> <p>Census payor type: Medicare: 34 Medicaid: 127 Other: 34 Total: 195</p> <p>Stage II Sample: 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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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F0279 SS=D	<p>Quality review completed 11/13/11 Cathy Emswiler RN</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). Based on observation, record review and interview, the facility failed to ensure a plan of care was initiated for non-pressure area skin conditions for 2 of 3 residents reviewed of the 4 who met the criteria for non-pressure area skin conditions in the stage 2 sample of 30. (Residents #90 and #281)</p> <p>Findings include:</p>	F0279	<p>F – 279 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of</p>	12/07/2011	

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	<p>1. On 11/1/11 at 10:19 a.m., Resident #281 was seated in her room in her wheelchair. The resident's abdomen was exposed and areas of purple/blue bruising were observed.</p> <p>The record for Resident #281 was reviewed on 11/2/11 at 1:52 p.m. The resident's diagnoses included, but was not limited to, diabetes mellitus.</p> <p>The Nursing Admission Assessment dated 10/4/11, indicated the resident had a bruise on the left upper arm and right inner forearm.</p> <p>The Nursing Assessments dated 10/24 and 10/31/11, indicated the resident had bruising to the left arm, right arm, and right abdomen.</p> <p>The plan of care dated 8/23/11, was reviewed. The resident did not have a current care plan related to the bruising and/or being at risk for bruising.</p> <p>Interview with the 4th floor unit manager on 11/3/11 at 12:33 p.m., indicated the bruising was more than likely from the resident's insulin shots and documentation should have been completed.</p>		<p>Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?As it relates to Resident 90 and Resident 281 the facility offers the following, upon surveyor observation cares plans were initiated for both residents regarding identified non- pressure area skin conditions. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The facility will identify all other residents with non-pressure area skin conditions. The facility will ensure that each resident identified has a current Care Plan in place regarding non-pressure area skin conditions.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?As it relates to Resident 90, the facility currently has a Wound Care Identification Form in place which was revised to include confirmation of the initiation of a Care Plan for any newly identified skin tears. All Licensed Professional Staff will receive in-servicing related to the revised form prior to December 7, 2011. As it relates to Resident</p>	

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	2. On 10/31/2011 10:49 a.m., Resident #90 was observed in bed with a white bandage noted on his left		281, all incident reports will be reviewed by the Unit Directors to ensure that, if identified, all non-pressure skin conditions have a Care Plan in place. All new admission/re-admission charts will be reviewed by the Unit Directors to ensure that if non-pressure area skin conditions are identified during the admission process that a Care Plan is in place. All Licensed Professional Staff will receive in-servicing regarding the importance of ensuring that a Care Plan is generated upon identification of any non-pressure area skin condition.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The facility has developed a Quality Assurance Audit Tool for the purpose of monitoring non-pressure related skin conditions and the timely generation and initiation of a Care Plan. The Director of Nursing/or Designee will be responsible for compiling data and reporting findings to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months. <u>This audit will be completed on a monthly basis.</u> 5. By What Date the Systemic Changes Will Be Made? December 7, 2011.	

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	<p>arm.</p> <p>On 11/1/11 at 1:33 p.m., the resident was observed up in a wheelchair. There was a bandage on his left arm with the dressing dated 11/1/11.</p> <p>On 11/3/11 at 9:48 a.m., the wound nurse removed the white bandage from the resident's arm. There were two skin tears observed to the left inner arm and the left elbow. There was no drainage noted and both areas were red in color and beginning to scab.</p> <p>The record for Resident #90 was reviewed on 11/1/11 at 2:16 p.m.</p> <p>Review of Physician Orders dated 10/28/11, indicated apply steri strips to skin tear to elbow and cover with dry sterile dressing and cover with kerlix daily until healed. Another Physician Order dated 10/30/11, indicated left inner arm skin tear cleanse with normal saline and apply bacitracin ointment with dry sterile dressing daily until healed.</p> <p>Review of the current plan of care indicated there was no care plan for the treatment of the skin tear.</p> <p>Interview with RN #2 on 11/2/11 at</p>				

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F0282 SS=D	<p>10:18 a.m., indicated there was no care plan for the resident's new skin tear, she further indicated the wound nurse was to write the care plan and update it as needed.</p> <p>Interview with the wound nurse on 11/2/11 4:36 p.m., indicated a care plan for the resident's skin tear had not been completed. She further indicated she normally does the care plans for all skin problems, however, she did not complete one for this resident until today.</p> <p>3.1-35(a)</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 observation, record review, and interviews, the facility failed to follow Physician Orders related to a chair alarm for 1 of 3 residents reviewed for accidents of the 6 who met the criteria for accidents in the stage 2 sample of 30. (Resident #90)</p> <p>Findings include:</p> <p>On 11/1/11 at 1:33 p.m., Resident #90 was observed sitting up in a</p>	F0282	<p>F – 282 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page</p>	12/07/2011	

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	<p>wheelchair. At that time there was no wheelchair alarm noted to the chair.</p> <p>On 11/1/11 at 2:27 p.m., the resident was observed up in wheelchair, there was no wheelchair alarm noted to the chair.</p> <p>On 11/1/11 at 3:20 p.m., the resident was observed up in a wheelchair, there was no alarm noted to the back of the chair.</p> <p>On 11/2/11 at 9:24 a.m., CNA (Certified Nurse Aide) #3 was observed getting the resident up from bed. The resident was then observed in his wheelchair. After the CNA had finished grooming the resident she placed him in the hallway seated in his wheelchair. There was no alarm noted his chair.</p> <p>On 11/2/11 at 10:44 a.m., the resident was observed up in the wheelchair and there was no wheelchair alarm noted to the chair.</p> <p>Interview with CNA #3 on 11/2/11 at 1:33 p.m., indicated there was no alarm on the back of his chair when she got him up earlier that day. She further indicated she had to find an alarm for him to use.</p>		<p>one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to resident 90, upon surveyor observation of a wheelchair alarm not in place per physician's order the wheelchair alarm was immediately placed on the resident's wheelchair.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?As it relates to resident 90 the facility offers that a review of all residents with orders for wheelchair alarms will be completed to ensure all residents with wheelchair alarms have them in place per physicians order.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? All licensed staff will be provided with educational in-servicing to review the importance of ensuring all wheelchair alarms are in place per physicians order.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?The facility has developed a quality assurance tool for the purpose of monitoring those residents with wheelchair</p>		

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F0309 SS=D	<p>The record for Resident #90 was reviewed on 11/1/11 at 2:16 p.m.</p> <p>Review of Physician Orders dated 4/29/10 and the current 10/11 Physician Order Sheet, indicated a wheelchair alarm. Review of the current plan of care dated 8/23/11 indicated the resident was at risk for falls due to a history of falls. The nursing approaches were to provide a wheelchair alarm.</p> <p>Interview with RN #2 on 11/2/11 at 1:36 p.m., indicated she was the nurse working with the resident on 11/1/11 and today. She further indicated that she had signed the treatment book indicating the resident's alarm was in place on 11/1/11.</p> <p>3.1-35(g)(2)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure an ongoing assessment was</p>	F0309	<p>alarms to ensure they are in place per physicians order. The Facility Safety Officer will be responsible for compiling the data for this audit. The data collected from this audit will be submitted to the Quality Assurance Committee for review on a quarterly basis for a minimum of 6 months. <u>This audit will be performed on all shifts and will completed on a monthly basis.</u> 5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p> <p>F – 309 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a</p>	12/07/2011	

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	<p>completed related to bruising for 2 of 3 residents reviewed of the 4 who met the criteria for non-pressure related skin conditions in the stage 2 sample of 30. (Residents #281 and #285)</p> <p>Findings include:</p> <p>1. On 11/1/11 at 10:19 a.m., Resident #281 was observed seated in her wheelchair in her room. The resident's abdomen was exposed and areas of purple/blue bruising were observed.</p> <p>The record for Resident #281 was reviewed on 11/2/11 at 1:52 p.m. The resident's diagnoses included, but was not limited to, diabetes mellitus.</p> <p>The 10/4/11 Nursing Admission Assessment indicated the resident had a bruise to her left upper arm that measured 3 centimeters (cm) x 4 cm and a 5 cm x 7 cm bruise to the right inner forearm.</p> <p>There was no bruising documented on the 10/18/11 Nursing Assessment.</p> <p>The Nursing Assessments dated 10/24 and 10/31/11, indicated the resident had bruising to the left and right arm, and right abdomen. No measurements were documented on</p>		<p>Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to Resident 281 and Resident 285, the facility offers that upon surveyor observation a skin assessment was completed for each resident and the findings of the assessment were documented in the nursing progress notes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?The facility has committed to completing a skin assessment for each resident in order to identify any pressure or non-pressure area skin conditions currently present. The assessment will be documented on the facility Skin Assessment Form and placed in each resident's medical record. Upon surveyor observations an informal in-service was provided to all Licensed Professional Staff</p>		

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	<p>the assessment sheet nor on a skin sheet. There was also no assessment in the nursing progress notes between 10/18-10/31/11 as to when the bruising was found.</p> <p>An entry in the Nursing Progress Notes dated 11/2/11, indicated all of the resident's bruising had been resolved from admission. There was no assessment related to the abdominal bruising.</p> <p>Interview with the resident on 11/2/11 at 1:49 p.m., indicated that she may have received the bruises on her stomach from her insulin shots.</p> <p>Interview with LPN #3 on 11/2/11 at 2:29 p.m., indicated when a bruise was found, she would first go and ask the resident what happened. An incident report would be completed, the area would be measured and the physician and family would be notified.</p> <p>Interview with the 4th Floor Unit Manager on 11/3/11 at 12:33 p.m., indicated the bruising was more than likely from the resident's insulin shots. She further indicated measurements should have been documented when the bruises were found and documentation should have been</p>		<p>regarding the assessment of bruises post admission.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?As it relates to identification of bruising the facility has developed a Skin Assessment Form which will be utilized to document both pressure ulcers and non-pressure area skin conditions. This form will be included in the Admission Assessment Packet, the Weekly/Monthly Nursing Summary and the Incident Report Form. All Licensed Professional Staff will receive in-servicing regarding the completion of the Skin Assessment Form prior to December 7, 2011.As it relates to continuing assessment of bruising, the facility is committed to completing ongoing assessments of all residents identified with areas of bruising. Documentation of the assessment will be documented in the nursing progress notes daily until the area is resolved. All Licensed Professional Staff will receive in-servicing regarding documentation requirements relating to bruising prior to December 7, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?The facility has developed a Quality Assurance Audit Tool for the purpose of</p>		

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	<p>completed in the Nursing Progress Notes.</p> <p>2. On 11/01/2011 at 8:28 a.m., Resident #285 was observed sitting in her wheelchair in her room. At that time, the resident was observed with a red and purple bruise behind her right elbow and there was a red raised area on top of her right wrist.</p> <p>On 11/1/11 at 1:12 p.m., the resident was observed up in her wheelchair, wearing short sleeves. There was a red and purple bruise noted to her right arm behind the elbow and on the top of her right wrist area.</p> <p>The record for Resident #285 was reviewed on 11/1/11 at 1:13 p.m. The resident was admitted to the facility on 10/20/11 from the hospital. The resident's diagnoses included, but were not limited to, diabetes, hypertension, and cellulitis.</p>		<p>monitoring the identification and continuing documentation of non-pressure area skin conditions. The Director of Nursing/or Designee will be responsible for compiling data and reporting findings to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months. <u>This audit will be performed on a monthly basis.</u>5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p>		

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	<p>Review of the Initial Nursing Assessment dated 10/20/11, indicated the resident had multiple bruising to the left and right arms, on top of the left hand, the left antecubital, and the right anterior. There were no measurements taken of any of the bruising. There was no indication the resident had bruising behind her right elbow or right wrist area.</p> <p>Review of the history and physical from the hospital dated October 2011, indicated the resident did receive coumadin (an anticoagulant medication) and aspirin everyday.</p> <p>Review of Physician Orders dated 10/20/11, indicated the resident was currently receiving aspirin 81 milligram daily.</p> <p>Review of the weekly Nursing Assessment dated 10/25/11, indicated the resident had no bruising anywhere.</p> <p>Review of Nursing Progress Notes dated 10/20/11 through 11/1/11 at 10 a.m., indicated there was no assessment or documentation of any new bruising to the right elbow or right wrist area.</p>				

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F0311 SS=D	<p>Interview with the First Floor Unit Manager on 11/1/11 at 1:43 p.m., indicated bruises were only measured when a new one was discovered and an incident report was completed. She also indicated if a resident was admitted to the facility with bruising to their body, all the bruises should be documented and measured at the time of admission.</p> <p>Interview with Director of Nursing on 11/1/11 at 3:20 p.m., indicated there was an admission assessment policy that indicated the assessment would be completed accurately. She further indicated it was expected of the nurses to identify the bruises and measure them and follow up in one week.</p> <p>3.1-37(a)</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure restorative services were initiated after being discharged from physical therapy for</p>	F0311	F – 311 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was	12/07/2011	

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	<p>1 of 2 residents reviewed of the 2 who met the criteria for community discharge in the stage 2 sample of 30. (Resident #239)</p> <p>Findings include:</p> <p>The record for Resident #239 was reviewed on 11/1/11 at 2:10 p.m. The resident's diagnoses included, but were not limited to, status post colon resection, neuropathy, and osteoarthritis.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 6/17/11 indicated the resident required limited assistance and the physical assistance of one person for transfers. He required supervision and set up help for walking in the room and for dressing.</p> <p>The Quarterly MDS dated 9/6/11, indicated the resident required limited assistance ad the physical assistance of one person for transfers and for dressing. He did not walk in his room.</p> <p>The resident was admitted to the facility on 6/11/11. A Physician's Order dated 6/11/11, indicated a physical therapy evaluation had been completed and the resident was to receive physical therapy for six weeks</p>		<p>correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Resident 239, Resident 239 was screened by Physical Therapy and a Restorative Nursing Program was initiated on November 3, 2011. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All current residents who have been discontinued from a skilled therapy program within the past 60 days have been identified. A review of their medical record has been completed to determine if a Restorative Nursing Program was initiated. For those identified as not having a program, a therapy screen was completed to determine if a Restorative Nursing program was warranted. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?</p>		

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	<p>for gait training.</p> <p>A Physical Therapy Discharge Summary dated 7/15/11, indicated the resident partially met his goals, and he was unable to reach his ambulation and strength long term goal due to decreased cooperation in treatment. Therapy recommended the resident receive home health physical therapy and 24 hour supervision.</p> <p>An initial Social Service evaluation dated 6/11/11, indicated the resident's rehab potential was good and the resident's discharge plan was to go home.</p> <p>A Social Service Progress Note dated 7/13/11, indicated a family meeting was held related to discharge planning. The resident's daughter indicated the resident was going to be long term due to not having anyone at home to help her. On 7/19/11, the daughter indicated the resident was going to remain at the facility long term.</p> <p>After the decision to remain long term, documentation of a therapy assessment for restorative nursing services was not done.</p>		<p>The Rehabilitation department's Discharge Summary Forms have been updated to include an area for recommendations for Restorative Nursing Program including rationale as to whether or not a Restorative Program is warranted. Each therapist has been in-serviced regarding the revised Discharge Summary Form and rationale requirements. The Social Service staff and nursing Unit Directors have been in-serviced regarding the importance of informing Therapy of any change to discharge plans following the discontinuation of a skilled therapy program to ensure proper consideration of a Nursing Program. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? The Director of Rehab will be responsible for completing an audit of all residents who are discontinued from a skilled therapy program to determine if a Restorative Nursing Program has been recommended and appropriately followed through on. Data will be collected and will be reported to the Quality Assurance Committee quarterly for a minimum of 6 months. <u>This audit will be performed on a monthly basis.</u> 5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p>		

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	<p>Interview with CNA #5 on 11/1/11 at 2:38 p.m., indicated the resident has had some physical decline since he was admitted in June. Based on how he is feeling, depends on how much he can do.</p> <p>Interview with LPN #4 on 11/2/11 at 9:58 a.m., indicated the resident has had a decline since his admission. She indicated the resident could still use his call light and voice his needs. She indicated the resident needed to be transferred to the toilet and needed help getting dressed.</p> <p>The resident was assessed by therapy on 11/3/11 and the following recommendations were made:</p> <p>Restorative nursing program for aroam (active range of motion) to bilateral lower extremities in all planes with manual resistance and sit to stand repetitions to maintain/prevent a decline in transfers.</p> <p>Interview with the 5th Floor Unit Manager on 11/3/11 at 8:43 a.m., indicated it can be up to the Unit Manager to recommend a resident for Restorative. She also indicated it can be recommended by therapy at time of discharge.</p>				

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F0312 SS=D	<p>Interview with the 5th Floor Unit Manager on 11/3/11 at 12:44 p.m., indicated the resident was not reassessed by therapy for restorative after the resident's status was changed to long term. She also indicated he was assessed by therapy and recommendations were made for restorative therapy as of today.</p> <p>3.1-38(a)(2)(B)</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure incontinence care was provided in a timely manner for 1 of 3 residents of the 6 who met the criteria for urinary incontinence in the stage 2 sample of 30. (Resident #186)</p> <p>Findings include:</p> <p>On 10/31/11 at 2:44 p.m., Resident #186 was observed in his wheelchair in the hallway. The resident was seated across from the nurses' station. The front of the resident's sweat pants were wet as well as the inner thigh area. At 3:02 p.m., 3:17 p.m., and 3:50 p.m., the resident</p>	F0312	<p>F – 312 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to Resident 186, we respectfully</p>	12/07/2011

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	<p>remained in the hallway across from the nurses' station and his pants remained wet. Staff were observed to interact with the resident but he was not taken to his room for incontinence care.</p> <p>The record for Resident #186 was reviewed on 11/1/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to, stroke and seizure disorder.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 10/10/11, indicated the resident was dependent on staff for toileting with one staff assist. The MDS also indicated the resident did not have a current toileting program and was always incontinent of urine.</p> <p>The resident's October 2011 plan of care card, indicated the resident was incontinent of bowel and bladder and pads or briefs were used.</p> <p>Interview with CNA #2 on 11/3/11 at 12:28 p.m., indicated the resident was incontinent and he usually did not voice when he needed to be changed. She was not sure if he was on a toileting program and was not able to voice how often the resident needed to be checked. CNA #2 asked CNA</p>		<p>offer that we are unable, retrospectively, to take any direct action to address the observation of incontinence made by the surveyor at the time. The Unit staff members were provided with in-servicing relative to ensuring timely incontinence checks for all residents who are identified as being incontinent. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?We are confident that through on-going re-education of staff coupled with the enforcement of facility policy, procedure and our expectations that two hour incontinent checks will be completed timely, like circumstances will not recur in the future.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?We will provide formal in-service education to the nursing staff relative to the importance of providing timely incontinence care in order to prevent skin breakdown and promote resident dignity. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?Through our Quality Assurance program, an audit will be performed to ensure compliance with timely provision of incontinence care. This audit</p>		

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F0322 SS=D	<p>#4 at the time how often the resident was toileted and she indicated in the morning, after lunch, and before the end of the shift.</p> <p>Interview with RN #1 on 11/3/11 at 12:37 p.m., indicated the resident was incontinent and he did not voice the need to go to the bathroom. She indicated he should be checked every two hours since he doesn't state when he needs to go to the bathroom.</p> <p>Interview with the 4th Floor Unit Manager on 11/3/11 at 3:10 p.m., indicated the resident was incontinent and should have been changed in a timely manner.</p> <p>3.1-38(a)(3)(C)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure proper placement of a percutaneous endoscopic gastrostomy (PEG) tube was</p>	F0322	<p>will be performed by the facility Quality Assurance Nurse and/or designee and findings will be reported to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months. <u>This audit will be performed on a minimum of a monthly basis on all shifts.</u> 5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p> <p>F – 322 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of</p>	12/07/2011	

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	<p>completed prior to the administration of medication for 1 of 1 PEG tube medication pass observed in the stage 2 sample of 30. (Resident #45)</p> <p>Findings include:</p> <p>On 11/3/11 at 8:22 a.m., RN #3 was observed preparing medication for Resident #45. At that time, the nurse indicated the resident received all of her medication by the way of the PEG tube. The RN entered the resident's room and turned off the enteral feeding pump. The RN then flushed the PEG tube with 30 cubic centimeters (cc) of water and began administering each medication through the PEG tube. The RN did not check for placement of the PEG using a stethoscope or an air bolus prior to administering the medications.</p> <p>Review of the current 1/1/05 Enteral Medication Administration Policy provided by the Director of Nursing indicated staff were to check for correct placement of feeding tube prior to the administration of medication.</p> <p>Interview with RN #3 on 11/3/11 at 8:33 a.m., indicated that she did not check for PEG tube placement with</p>		<p>this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to Resident 45 the facility is unable to further retrospectively address the surveyor cited concern.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?The facility is confident that licensed staff education regarding the proper procedure for the administration of medications via a gastrostomy tube will ensure corrective action for all potentially affected residents. In the event the facility identifies like circumstances corrective action will be taken in the form of further education or disciplinary corrective action when warranted.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?An in-service will be provided to all Licensed Professional Staff regarding the proper procedure</p>		

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F0323 SS=D	<p>an air bolus and stethoscope prior to administering the medications.</p> <p>Interview with the Fifth Floor Unit Manager on 11/3/11 at 8:35 a.m., indicated it was the facility's policy to check for placement of the PEG tube before administering medications.</p> <p>3.1-44(a)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident was free from accidents related to chair alarms and siderails with gaps greater than 4 3/4 inches producing a potential for entrapment for 2 of 3 residents reviewed for accidents of the 6 residents who met the criteria for accidents in the stage 2 sample of 30. (Residents #77 and #90)</p> <p>Findings include:</p>	F0323	<p>for the administration of medications via a gastrostomy tube prior to December 7, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?The facility's Administrative Nursing Team will perform random evaluations of Licensed Professional Staff administering medications through a gastrostomy tube to ensure that the proper procedure is adhered to. <u>This audit will be performed on a monthly basis on all shifts.</u> 5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p> <p>F – 323 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following:1.</p>	12/07/2011	

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	<p>1. On 11/1/11 at 1:33 p.m., Resident #90 was observed sitting up in a wheelchair. At that time there was no wheelchair alarm noted to the chair.</p> <p>On 11/1/11 at 2:27 p.m., the resident was observed up in wheelchair, there was no wheelchair alarm noted to the chair.</p> <p>On 11/1/11 at 3:20 p.m., the resident was observed up in a wheelchair, there was no alarm noted to back of chair.</p> <p>On 11/2/11 at 9:24 a.m., CNA (Certified Nurse Aide) #3 was observed getting the resident up from bed. The resident was then observed in his wheelchair. After the CNA had finished grooming the resident she placed him in the hallway seated in his wheelchair. There was no alarm noted his chair.</p> <p>On 11/2/11 at 10:44 a.m., the resident was observed up in the wheelchair and there was no wheelchair alarm noted to the chair.</p> <p>Interview with CNA #3 on 11/2/11 at 1:33 p.m., indicated there was no alarm on the back of his chair when she got him up earlier that day. She</p>		<p>What corrective action(s) were accomplished for those residents found to have been affected by the deficient practice? As it relates to Resident 90 the facility offers that upon surveyor observation of a wheelchair alarm not in place per physician's order the wheelchair alarm was immediately placed on the resident's wheelchair. As it relates to Resident 77 the facility offers that upon surveyor observation of cited side rails in place the side rails were immediately removed and replaced with side rails meeting FDA Hospital Bed Dimensional Limit Recommendations.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? As it relates to Resident 90 the facility offers that a review of all residents with orders for wheelchair alarms will be completed to ensure all residents with orders for wheelchair alarms have the alarms in place per physicians order. As it relates to Resident 77 the facility offers that a review of all side rails in place in the facility was completed on November 1, 2011. This audit consisted of a measurement of entrapment zones to ensure each side rail met the FDA Hospital Bed Dimensional Limit Recommendations.3. What measures have been put into place or what systematic changes</p>		

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	<p>further indicated she had to find an alarm for him to use.</p> <p>The record for Resident #90 was reviewed on 11/1/11 at 2:16 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, Alzheimer's, Parkinson's, and dementia with behavioral disturbance.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 8/24/11, indicated the resident was not alert and oriented, and was totally dependent with a two person assist with transfers, dressing, personal hygiene, and bathing. The resident had lower extremity impairment to one side.</p> <p>Review of the fall risk assessment dated 10/28/11, indicated the score of 15 which meant the resident was a high risk for falls.</p> <p>Review of Physician Orders dated 4/29/10 and the current 10/11 Physician Order Sheet, indicated a wheelchair alarm. Review of the current plan of care dated 8/23/11, indicated the resident was at risk for falls due to a history of falls. The nursing approaches were to provide a wheelchair alarm.</p>		<p>will be made to ensure that the deficient practice does not recur? As it relates to resident 90 the facility is committed to educating Nursing Staff regarding the importance of ensuring wheelchair alarms are in place per physician order. As it relates to resident 77 the facility is confident that by discarding all similar side rails re-educating maintenance staff on the FDA Hospital Bed Dimensional Limit Recommendations this will not recur.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? As it relates to Resident 90 the facility has developed a Quality Assurance Tool for the purpose of monitoring those residents with wheelchair alarms to ensure they are in place per physicians order. The facility Safety Officer will be responsible for compiling the data for this review. All nursing staff will be in-serviced on the provision of wheelchair alarms for safety per physicians order. Data collected from the aforementioned audit will be submitted to the Quality Assurance Committee for review on a quarterly basis. <u>This audit will be performed on all shifts and will completed on a monthly basis.</u> As it relates to Resident 77 the facility has developed a Quality Assurance Tool for</p>		

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	<p>Nurses notes dated 10/28/11 at 2:40 p.m., indicated called to room by physical therapy staff, resident was observed on the floor in a fetal left side position. He sustained a skin tear to the left elbow and left inner arm. His left hip and shoulder had redness.</p> <p>The Incident report dated 10/28/11, indicated the resident was found on the floor in fetal left side position. He obtained skin tear times two.</p> <p>Interview with RN #2 on 11/2/11 at 1:36 p.m., indicated she was the nurse working with the resident on 11/1/11 and today. She further indicated that she had signed the treatment book indicating the resident's alarm was in place on 11/1/11.</p> <p>2. On 11/1/11 at 9:21 a.m., Resident #77 was observed in bed. 1/2 side rails were noted in the up position on both sides of the resident's bed. There were four bars which divided each side rail into five sections. The first and fifth sections had open spaces measuring 5 1/2 inches across and 12 inches up and down. The second and fourth sections had open spaces measuring 5 1/2 inches</p>		<p>the purpose of monitoring all side rails in place in the facility to ensure the measurements are consistent with the FDA Hospital Bed Dimensional Limit Recommendations. This audit will completed by facility Administration and data will be compiled by the facility Safety Officer. Data collected from the aforementioned audit will be submitted tothe Quality Assurance Committee for review on a quarterly basis. <u>This audit will be performed on a monthly basis.</u>5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p>				

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	<p>across and 18 inches up and down. The open space of the third section measured 7 1/2 inches across and 18 inches up and down.</p> <p>The record for Resident #77 was reviewed on 11/1/11 at 1:50 p.m. The resident's diagnoses included, but were not limited to, neuropathy, insomnia, peripheral vascular disease, depression, and rheumatoid arthritis.</p> <p>The 8/24/11 Minimum Data Set (MDS) quarterly assessment indicated the resident was cognitively intact and had no falls since the last assessment. The MDS assessment also indicated the resident required extensive assistance of two persons for transfers and bed mobility and was dependent on staff for personal hygiene and dressing.</p> <p>The 9/7/11 Side Rail Assessment indicated the resident was not ambulatory and did not attempt to get out of bed without assistance. The assessment also indicated the resident was able to turn herself side to side with the help of staff and the side rails were used to assist the resident from lying to sitting/sitting to lying position. The resident was to have 1/2 side rails to be used for</p>			

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	<p>positioning/transfers.</p> <p>The "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" as "Guidance for Industry and FDA Staff" document issued on March 10, 2006 was reviewed. The document indicated to reduce head entrapment the opening in the bed systems side rails should be small enough to prevent a resident's head from entering. The document indicated the space between the openings in the side rails should be less than 4 3/4 inches to prevent a resident's head from entering.</p> <p>When interviewed on 11/1/11 at 10:00 a.m., the facility Administrator was informed of the measurements of the open gaps in the resident's side rails.</p> <p>When interviewed on 11/1/11 at 11:33 a.m., the facility Administrator indicated staff were currently staying with the resident until the side rails could be replaced related to the possible hazard from the size of the space between the bars on the side rails. The facility Administrator also indicated the side rails were to be changed due to size of the open spaces on the rails.</p>				

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F0329 SS=D	<p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the residents were free of unnecessary drugs related to the inadequate monitoring of anticoagulant therapy related to the lack of obtaining a PT/INR (Protime/International Normalized Ratio) as ordered. The facility also failed to ensure residents</p>	F0329	F - 329 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in	12/07/2011	

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	<p>receiving antipsychotic medications received gradual dose reductions and only received the medications to treat specific diagnosed conditions. This deficient practice affected 1 of 10 residents reviewed for unnecessary medications in the stage 2 sample of 30 and 1 of 3 residents reviewed for psychoactive medications of the 6 residents who met the criteria for psychoactive medication use in the stage 2 sample of 30. (Resident #44)</p> <p>Findings include:</p> <p>The record for Resident #44 was reviewed on 11/2/11 at 9:28 a.m. The resident had diagnoses that included, but were not limited to, Parkinson's disease, dementia with behavioral disturbances, anxiety and atrial fibrillation (an irregular heart rhythm).</p> <p>There was an order dated 9/6/11, that was written by the Nurse Practitioner that indicated Coumadin (an anticoagulant medication) 1 mg (milligram) was to be administered to the resident starting on 9/8/11.</p> <p>There was a order dated 9/29/11, that was written by the Nurse Practitioner that indicated to change Coumadin to 1.5 mg by mouth daily. She also</p>		<p>this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?As it relates to anti-coagulant therapy the facility offers that upon surveyor observation, the Coumadin 1.5 mg was stopped and a PT/INR was completed. The results were within normal limits. Physicians' orders were then given for Coumadin 1 mg to begin on November 4, 2011. The licensed professional responsible for not transcribing the order was identified and was provided with an educational counseling. As it relates to lack of a Gradual Dose Reduction of an anti-psychotic medication for resident 44 the facility offers that the Risperdal was decreased to .25 mg daily on November 11, 2011. The facility is committed to monitoring Resident 44 for the reemergence of target symptoms and/or symptoms of withdrawal. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? As it relates to anti-coagulant therapy the facility offers that a review of all residents receiving</p>		

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	<p>indicated that a PT/INR (a laboratory test to assess bleeding) Normal was to be obtained in 2 weeks.</p> <p>Review of the laboratory results indicated that on 9/29/11 a PT/INR was done and the results were PT 16.7 and INR 1.6.</p> <p>Review of the Nurse Practitioner's progress note dated 9/29/11 indicated, "History of Present Illness Anticoagulation (Follow-Up). The patient is currently anticoagulated with warfarin (Coumadin) for atrial fibrillation. Anticoagulation status: the patient's INR goal is 2-2.5 and her INR is too low. INR 1.6 on Coumadin 1 mg daily. She has no significant events. Symptoms: Symptoms since the last visit: no easy bleeding, no easy bruising, no epistaxis, no melena and no hematuria. Missed doses? No."</p> <p>The PT/INR was obtained on 10/14/11. The results were PT 44.9 and INR 4.3. The Nurse Practitioner was notified on 10/14/11 and orders were obtained.</p> <p>The order dated 10/14/11 indicated, "Hold Coumadin, recheck PT/INR on Monday (10/17/11)."</p>		<p>anti-coagulation therapy was completed to ensure appropriate residents PT/INR testing was completed, proper physician notification occurred and follow up orders were completed. As it relates to dose reduction of anti-psychotic medications the facility is committed to reviewing all residents with an order for anti-psychotic medication to ensure there are appropriate diagnoses and indications for the medication and that required attempts at Gradual Dose Reduction of the medication have occurred within the last year. For those residents identified as not having a recent attempt at a Gradual Dose Reduction, the facility, in collaboration with the physician, will ensure there is an appropriate reason for the clinical contraindication of attempts at Gradual Dose Reduction. 3. What measures will be put into place or systematic changes will be made to ensure the deficient practice does not recur? As it relates to anti-coagulant therapy, Facility Licensed Professional staff will be provided with educational in-servicing to review the facility policy and follow through for all physician orders to ensure a like circumstance will not recur. As it relates to dose reduction of anti-psychotic medication the facility has developed a policy for psychoactive medications that</p>				

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	<p>Review of the laboratory tests indicated the Prottime/INR was not obtained on 10/17/11 as ordered by the Nurse Practitioner.</p> <p>Interview with the 3rd Floor Unit Manager on 11/2/11 at 11:18 a.m., indicated the PT/INR was not drawn on Monday 10/17/11 as ordered by the Nurse Practitioner, the last PT/INR that was obtained was dated 10/14/11.</p> <p>On 11/3/11 at 8:30 a.m., the record was reviewed, there was an order dated 11/2/11 for a stat (immediate) PT/INR. The PT/INR was collected on 11/2/11 at 11:49 a.m. The PT was 33.3 and INR 3.2 .</p> <p>There was an order written by the Nurse Practitioner dated 11/2/11</p> <ol style="list-style-type: none"> 1. DC Coumadin 1.5 mg 2. Start Coumadin 1 mg daily on 11/4/11 3 PT/INR on 11/11/11 <p>The Quarterly MDS (Minimum Data Set Assessment), dated 10/20/11, for Resident #44 was reviewed. The assessment indicated the resident could be understood and could understand others. The BIMS (Brief Interview for Mental Status) score was 9, which indicated the resident was</p>		<p>specifies requirements and the procedure for Gradual Dose Reduction. All licensed professionals as well as Social Service staff will be educated on this policy and procedure. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The facility has developed a Quality Assurance Tool for the purpose of monitoring those residents receiving anti-coagulation therapy to ensure physician ordered PT/INRs are drawn, MD is notified of the result and all follow up orders are complete. The facility Quality Assurance Nurse will be responsible for compiling the data related to this audit. The results of this audit will be submitted to the Quality Assurance Committee for review on a quarterly basis for a minimum of 6 months. The facility has developed a Quality Assurance Tool for the purpose of monitoring those residents that receive anti-psychotic medications. This audit will ensure there is a clinical reason/diagnosis for the use of the anti-psychotic medication and that there is a documented attempt to reduce the medication in two separate quarters within the first year and annually thereafter. In those cases where gradual dose reduction is clinically contraindicated the reason will be</p>				

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	<p>moderately cognitively impaired. There were no behaviors indicated on the MDS.</p> <p>The current Physician Order Sheet dated October 2011, indicated the resident was receiving Risperdal (an antipsychotic medication) 0.5 mg once daily for anxiety.</p> <p>Interview with the Administrator on 11/7/11 at 9:13 a.m., indicated the resident had been receiving Risperdal 0.5 mg daily since 1/4/2010.</p> <p>The current care plan, dated 4/28/11 and revised 10/20/11, indicated the resident received a psychoactive medication due to the diagnosis of dementia with behavioral disturbances, anxiety. The interventions included: -monitor behaviors via flow sheet -attempt to reduce quarterly monitor for adverse reactions</p> <p>The care plan, dated 10/8/11, indicated, the resident becomes easily annoyed with verbal outbursts at staff at times. The interventions included: -allow res to express self -active listening -remind of appropriate communication with others</p>		<p>documented in the medical record. The results of this audit will be submitted to the Quality Assurance Committee for review on a quarterly basis for a minimum of 6 months. <u>This audit will be performed on a monthly basis.</u> 5. By What Date The Systemic Changes Will Be Completed? December 7, 2011</p>		

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	<p>Review of the behavior intervention monthly flow records for January 2011 through October 2011 indicated no anxiety or verbal outbursts were documented. The only behaviors documented on the behavior flow records were vaginal itching, which was documented as occurring on 1/8/11, 4/3/11, 5/19/11, and on 5/25/11. No other behaviors were documented for the months of January through October 2011.</p> <p>The Social Service progress note dated 5/28/11, indicated, "...The resident's mood seems stable and has had no behavioral occurrences over the past month..." The Social Service progress note dated 6/23/11, indicated, "...No mood stated or behavioral occurrences have been reported by staff during the past month..." The Social Service progress note dated 8/24/11, indicated, "... No reports of change in mood state or behavioral occurrences..." The Social Service Note dated 9/26/11, indicated, "...Staff have not reported any change in mood state or behavioral occurrences over this past month..."</p> <p>The 3rd floor Social Worker was interviewed on 11/2/11 at 1:37 p.m.</p>			

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	<p>She indicated the resident has history of verbally and physically aggressive behavior. She indicated all behaviors were charted on the behavior flow sheet. She indicated that she reviewed the behavior flow sheets and the resident did not have documentation of any anxious of aggressive behaviors. She indicated there were no specific targeted behaviors exhibited by the resident that indicated the use of the medication Risperdal.</p> <p>There was a Pharmacy Consultant Report, dated 12/27/11, that indicated, "Comment: (Resident's name) has taken 0.5 mg once daily since 3/25/10. Federal nursing facility regulation require that antipsychotics being used to manage behavior or stabilize mood undergo gradual dose reduction (GDR) attempts in two separate quarters within the first year in which a resident is admitted on one of these medication or after the facility has initiated the medication, then annually thereafter unless contraindicated. Recommendation: Please consider a gradual dose reduction, perhaps decreasing to Risperdal 0.25 mg daily while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to</p>			

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	<p>continue at the current dose, please provide rational describing a dose reduction is clinically contraindicated."</p> <p>The Physician signed the report on 12/30/10 and declined the recommendation from the Pharmacist indicating the GDR was clinically contraindicated for the individual. The Physician did not provide the required patient specific rationale describing why a GDR attempt was contraindicated.</p> <p>On 11/2/11 at 2:03 p.m., the 3rd floor Unit Manager was interviewed. She indicated that she was responsible for monitoring the gradual dose reductions. She indicated the physician did not document his rationale for not reducing the dose of the Risperdal on the December 2010 Pharmacy Consultant Report. She indicated there should be documentation of the reason for not reducing the medication.</p> <p>3.1-48(a)(3) 3.1-48(b)(1) 3.1-48(b)(2)</p>			

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F0333 SS=D	<p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure the residents were free of significant medication errors related to the continued administration of Coumadin after the Nurse Practitioner ordered it to be held for 1 of 10 residents reviewed for unnecessary medications, in the stage 2 sample of 30. (Resident #44)</p> <p>Findings include:</p> <p>The record for Resident #44 was reviewed on 11/2/11 at 9:28 a.m. The resident had diagnoses that included, but were not limited to, Parkinson's disease, dementia with behavioral disturbances, anxiety and atrial fibrillation (an irregular heart rhythm).</p> <p>There was an order dated 9/6/11, that was written by the Nurse Practitioner that indicated Coumadin (an anticoagulant medication) 1 mg (milligram) was to be administered to the resident starting on 9/8/11.</p> <p>There was a order dated 9/29/11, written by the Nurse Practitioner that indicated to change Coumadin to 1.5</p>	F0333	<p>F – 333 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to Resident 44, upon notification, the Coumadin 1.5 mg was stopped on November 2, 2011 and a PT/INR was completed. The results were within normal ranges. Physician's orders were then given for Coumadin 1 mg to begin on November 4, 2011. The licensed professional responsible for not transcribing the order was identified and was provided with educational counseling.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?The facility has identified all other residents</p>	12/07/2011

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	<p>mg by mouth daily. She also indicated that a PT/INR (Protime/International Normalized Ratio) (a laboratory test to assess bleeding) was to be obtained in 2 weeks.</p> <p>Review of the laboratory results indicated that on 9/29/11 a PT/INR was done and the results were PT 16.7 and INR 1.6.</p> <p>The Nurse Practitioner's progress note dated 9/29/11 indicated,"History of Present Illness Anticoagulation (Follow-Up). The patient is currently anticoagulated with warfarin (Coumadin) for atrial fibrillation. Anticoagulation status: the patient's INR goal is 2-2.5 and her INR is too low. INR 1.6 on Coumadin 1 mg daily. She has no significant events. Symptoms: Symptoms since the last visit: no easy bleeding, no easy bruising, no epistaxis, no melena and no hematuria. Missed doses? No."</p> <p>The PT/INR was obtained on 10/14/11. The results were PT 44.9 and INR 4.3. The Nurse Practitioner was notified 10/14/11 and orders were obtained.</p> <p>The order dated 10/14/11 indicated, "Hold Coumadin, recheck PT/INR on Monday (10/17/11)."</p>		<p>in the facility with physician orders for Coumadin therapy. The physicians orders were reviewed and it was determined that there were no other like circumstances of Coumadin being placed on hold by the physician without appropriate follow-through.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Facility Licensed Professional staff will be provided with educational in-servicing to review the facility policy on transcription and follow through for all physician orders to ensure a like circumstance does not recur. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? Each nursing Unit Director is responsible for the daily review of physician orders to ensure that all necessary steps are taken following an order being received. Through this review it is expected that orders for medications that have been put on hold can readily be verified by the Unit Director to prevent future like circumstances. Additionally, through the facility Quality Assurance Program, an audit will be completed by the facility Quality Assurance Nurse to ensure there is compliance with adherence to physician orders relative to the use of Coumadin.</p>		

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F0412 SS=D	<p>The October 2011 MAR (Medication Administration Record) was reviewed. The MAR indicated the Coumadin 1.5 mg was administered to the resident from 10/14/11 through 11/1/11, the Coumadin was not held as ordered on 10/14/11.</p> <p>Interview with the 3rd floor Unit Manager on 11/2/11 at 11:18 a.m., indicated the Coumadin was not held as ordered. She indicated the Coumadin 1.5 mg was administered to the resident from 10/14/11 through 11/1/11.</p> <p>3.1-48(c)(2)</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review, and interview, the facility failed to ensure annual dental exams were</p>	F0412	<p>The findings will be compiled and reported to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months. <u>This audit will be performed on a monthly basis.</u>5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p> <p>F - 412 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a</p>	12/07/2011	

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	<p>provided for 1 of 2 residents reviewed for dental services of 2 who met the criteria for dental services in the stage 2 sample of 30. (Resident #77)</p> <p>Findings include:</p> <p>On 11/1/11 at 9:32 a.m., Resident #77 was observed in her room. The resident was missing several of her lower teeth.</p> <p>The record for Resident #77 was reviewed on 11/1/11 at 1:50 p.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis, high blood pressure, neuropathy, and depression. A consent form for the resident to receive the available on-site dental services was signed by the resident's authorized sponsor on 9/30/10.</p> <p>The 6/9/11, 9/7/11 and 10/11/11 Nursing assessments indicated some of the residents teeth were missing. A care plan dated 10/20/11 indicated the resident was at risk for oral pain related to having broken teeth.</p> <p>The most recent Dental progress note was dated 5/11/11. The note indicated the resident was not seen and was to be rescheduled. There</p>		<p>Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Resident 77, upon surveyor observation a plan was put in place to ensure the resident was seen by the dentist during the next scheduled visit. A dental exam was completed for Resident 77 on November 10, 2011. The dentist has recommended a deep cleaning in 3 months.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The facility Social Service staff has completed a review of all residents in the facility to identify those residents with consents for dental treatment. The facility will ensure all those with consents for dental treatment have received dental services within the last year. For those residents without consent for in house dental treatment Social</p>	

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	<p>were no further Dental progress notes in the resident's clinical record.</p> <p>When interviewed on 11/1/11 at 3:28 p.m., Social Worker #2 indicated the Dentist comes to the facility monthly and the resident should have been seen annually.</p> <p>When interviewed on 11/2/11 at 11:00 a.m. at 9:57 a.m., the 2nd Floor Social Worker indicated Resident #77 was last seen by the Dentist on 5/26/2010. The Social Worker indicated Resident #77 was due for an annual oral exam by the Dentist in 5/2011.</p> <p>When interviewed on 11/2/11 at 11:00 a.m., the 2nd Floor Social Worker indicated the Dentist was in the facility 7/11/11, 8/13/11, and 9/21/11 and the resident should have been seen for an annual Dental visit as she was not seen on 5/11/11 when her annual visit was due.</p> <p>3.1-24(a)(1)</p>		<p>Service will discuss the available services with the resident's appropriate representative.3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The facility has developed a policy and procedure for routine dental services. This policy entails that routine dental services, emergency dental services and timely denture repair be provided to residents within the facility who have requested these services. The Social Service staff has been educated on this policy as well as their responsibility to maintain a log for the purpose of tracking all Residents dental visits. 4. How the corrective actions will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place? The facility has developed a Quality Assurance Audit Tool for the purpose of monitoring those residents with dental consents to ensure dental services are provided on an annual basis. The facility Social Service Director will be responsible for compiling data and reporting the findings to the Quality Assurance Committee for review on a quarterly basis for the period of one year. <u>This audit will be performed on a monthly basis.</u>5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p>		

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F0425 SS=E	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation and interview, the facility failed to ensure the Intravenous (IV) fluids in the Emergency Drug Kit (EDK) were not expired related to 1 of 2 IV EDK tubs stored in the facility. (The Second Floor IV EDK tub) This had the potential to effect 176 residents of the 195 residing in the facility.</p> <p>Findings include:</p> <p>On 11/3/11 at 9:57 a.m., observation of the second floor medication room indicated an IV EDK box located on the floor near the refrigerator. The contents in the box had expiration date of 10/31/11.</p>	F0425	<p>F - 425 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following:1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Upon surveyor observation, the pharmacy was notified of the</p>	12/07/2011	

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	<p>Inside the box were two IV bags of .45 normal saline 1000 milliliters (ml), two bags of .9 normal saline 1000 ml, two bags of D5 .45 normal saline 1000 ml, one bag of D5 Lactated ringers 1000 ml, one bag of lactated ringers 1000 ml, two bags of levoquin 500 milligrams (mg) 100 ml, and two bags of vancomycin 500 mg, and one bag of vancomycin 1 gram.</p> <p>There was an IV EDK box on the first floor, the contents of the box were not expired. 19 residents resided on the first floor.</p> <p>Interview with the Second Floor Unit Manager on 11/3/11 at 10:05 a.m., indicated the IV EDK box had expired and he was responsible for checking it daily.</p> <p>3.1-25(a)</p>		<p>expired IV EDK Kit and it was immediately replaced.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All IV EDK Kits in the facility were identified and determined to be current.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The Pharmacy has committed to exchanging all EDK Kits on a monthly basis to ensure all EDK kits are within their expiration dates.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?An EDK Expiration Date Checklist Audit Form has been developed to ensure that all kits in the facility are current. The completed audit tool will be provided monthly to the Director of Nursing for review and the findings will be presented to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months. <u>This audit will be performed by the floor Unit Directors.</u>5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p>		

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F0441 SS=E	<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> <p>Based on observation, record review and interview, the facility failed to ensure handwashing was completed after glove removal for 1 resident in the Stage 2 Sample of 30. The facility</p>	F0441	F - 441 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of	12/07/2011

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	<p>also failed to ensure gloves were worn during the administration of eye drops for 1 of 1 eye drop administrations observed, the facility also failed to ensure the glucometer was disinfected after use for 1 of 1 glucometers observed and the facility failed to ensure gloves were worn while giving a subcutaneous injection for 1 of 1 injections observed in the stage 2 sample of 30. (Residents #6, #127, #283, and #286)</p> <p>Findings include:</p> <p>1. On 11/4/11 at 11:05 a.m., CNA #1 was observed to enter Resident #127's room. The CNA put a glove on her left hand and proceeded to empty the resident's urinal. After emptying the urinal, the CNA removed the glove and placed the glove in the trash can and walked out of the resident's room. The CNA did not wash her hands after removing the glove and prior to leaving the resident's room.</p> <p>Interview with the Director of Nursing on 11/7/11 at 9:30 a.m., indicated the CNA should have washed her hands after removing the glove and prior to leaving the resident's room.</p>		<p>this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated November 15, 2011, the facility offers the following:1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to C.N.A. 1 and Resident 127, the facility is unable to retrospectively offer any further corrective action.As it relates to LPN 1 and Resident 286, the facility reviewed the manufacturer recommendations relative to cleaning of glucometers. The facility has elected to revise its policy and procedure to include the disinfection of all glucometers after each use with a disposable surface disinfectant.As it relates to LPN 1 and Resident 6, the facility is unable to retrospectively offer any further corrective action.As it relates to LPN 2 and Resident 283, the facility is unable to retrospectively offer any further corrective action.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?As it relates to proper hand washing following the removal of gloves,</p>		

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			we feel confident that on-going education of staff will ensure substantial compliance in the future. Additionally, the facility is committed to administering corrective action if future occurrences take place including education as well as progressive discipline, if warranted.As it relates to the sanitation of glucometers after use, the facility has chosen to revise our policy and procedure to include disinfection of all glucometers after each use with a disposable surface disinfectant. Disposable surface disinfectants will be stored on each medication cart where glucometers are stored between uses.As it relates to the wearing of gloves for the administration of eye drops, we feel confident on-going education of staff will ensure substantial compliance in the future. Additionally, the facility is committed to administering corrective action if future occurrences take place including education as well as progressive discipline, if warranted.As it relates to the wearing of gloves for the administration of subcutaneous injections, we feel confident that on-going education of staff will ensure substantial compliance in the future. Additionally, the facility is committed to administering corrective action if future occurrences take place including education as well as progressive		

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			discipline, if warranted.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?Through the facility In-Service and Education Program, we are committed to providing nursing staff with a review of our Infection Control policies which address requirements for proper hand washing following the removal of gloves, sanitation of glucometers after use, and the use of gloves for administration of both eye drops and subcutaneous injections. We are committed to providing future in-service programs periodically throughout the year to ensure ongoing compliance with Infection Control policies and procedures.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?The facility will monitor compliance with Infection Control policies and procedures through the use of random skills checks of nursing staff members. Checks will be made by the facility Quality Assurance Nurse, Infection Control Nurse and/or Designee who will be responsible for making unannounced observations of staff to verify adherence to the policies for proper hand washing following the removal of gloves, sanitation of glucometers after use, and the use of gloves for administration of		

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	<p>2. On 11/2/11 at 3:52 p.m., LPN #1 was observed passing medications. At that time, the LPN performed a glucometer check for Resident #286. The LPN indicated that each resident had their own glucometer to check for blood sugars. After the LPN had obtained the blood sugar reading from the glucometer, she cleaned the glucometer with an alcohol wipe and placed it back into the medication cart drawer. The nurse did not disinfect the machine with any type of germicidal wipe or cleaner.</p> <p>Review of the current Disinfection policy dated 4/14/10 provided by the Director of Nursing, indicated reusable equipment was disinfected and sanitized based upon manufacturer's recommendations and/or general disinfection methods using germicidal cleaning products, Lysol cleansing wipes and/or alcohol prep pads.</p>		<p>both eye drops and subcutaneous injections. Data will be compiled and reported to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months. <u>This audit will be performed on a monthly basis on all shifts.</u> 5. By What Date The Systemic Changes Will Be Completed? December 7, 2011.</p>		

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	<p>Review of the Compliance glucometer quality control manual version 1.1 February 2009 provided by the Director of Nursing, indicated to clean and disinfect the meter exterior, wipe with a surface disinfectant.</p> <p>Interview with the Director of Nursing on 11/4/11 at 9:16 a.m., indicated she understood the machine should have been disinfected after each regardless if every resident had their own glucometer.</p> <p>3. On 11/2/11 at 4:06 p.m., LPN #1 was observed passing medications for Resident #6. The nurse indicated the resident was to receive eye drops, one eye drop into each eye. The nurse reached in the medication cart and removed the bottle of eye drops Brimonidipine .2% and walked into the resident's room.</p> <p>At that time she proceeded to place one drop into each of the resident's eyes. The LPN did not wear gloves while placing the eye drops in his eyes. She then threw away the Kleenex and washed her hands with soap and water in the resident's bathroom.</p> <p>Interview with LPN #1 at the time, indicated she did not wear gloves</p>			

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	<p>while administering the eye drops and she further indicated she should have worn the gloves.</p> <p>Review of the current 11/1/97 Standard Precautions Policy provided by the Director of Nursing indicated gloves shall be worn when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and non intact skin.</p> <p>Interview with the Director of Nursing on 11/3/11 at 11:17 a.m., indicated the nurse should have worn gloves while administering the eye drops.</p> <p>4. The morning Medication Administration Pass was observed on 11/2/11 at 8:15 a.m. LPN #2 prepared an injection of Heparin 5,000 units to administer to Resident #283. The LPN did not have any gloves on. The LPN entered the resident's room with a syringe of Heparin. LPN #2 then administered the injection to the resident. The LPN did not have disposable gloves on while administering the injection in the resident's abdomen. After administering the injection to resident the LPN then returned to the medication cart with the syringe in her hand and disposed of the empty</p>				

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	<p>syringe in the container on the medication cart.</p> <p>The record for Resident #283 was reviewed on 11/2/11 at 11:15 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease and high blood pressure. Review of the current physician orders indicated there was a physician's order for the resident to receive Heparin 5,000 units injected subcutaneously every 12 hours.</p> <p>The facility policy titled "Medication Administration" was received from the Director of Nursing and reviewed on 11/3/11 at 12:20 p.m. The policy was dated January 2009. The Director of Nursing indicated the policy was current.</p> <p>The policy indicated gloves were to worn for the administration of subcutaneous injections.</p> <p>When interviewed on 11/3/11 at 12:20 p.m., the Director of Nursing indicated gloves were to be worn when administering subcutaneous injections as per the facility policy.</p> <p>3.1-18(l)</p>				

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

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FORM APPROVED

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