

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155754	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2014
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NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 28070 CR 24 ELKHART, IN 46517
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F000000	<p>This visit was fro a Recertification and State Licensure Survey.</p> <p>Survey Dates: February 17, 18, 19, 20, 21, 24, & 25, 2014</p> <p>Facility number: 001131 Provider number: 155754 AIM number: 200823940</p> <p>Survey Team: Deb Kammeyer, RN-TC Lora Swanson, RN Julie Wagoner, RN Pam Williams, RN Julie Ferguson, RN (February 17, 18, 19, 20, & 21, 2014)</p> <p>Census bed type: SNF: 53 SNF/NF: 4 Residential: 97 Total: 154</p> <p>Census payor type: Medicare: 21 Medicaid: 4 Private: 129 Total: 154</p> <p>Sample: 8</p> <p>These deficiencies reflect State</p>	F000000		

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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F000280 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on March 4, 2014, by Brenda Meredit, R.N.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to revise a comprehensive care plan for 1 of 5 residents reviewed for unnecessary medications. (Resident #18)</p> <p>Findings include:</p>	F000280	<p><u>What corrective action will be done by the facility?</u> Resident#18 has her care plan revised to reflect the discontinuation of her hypnotic medication. <u>How will the facility identify other residents having the potential to be affected by the same practice and what</u></p>	03/25/2014	

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	<p>The record review for Resident #18 was completed on 2/20/14 at 10:00 A.M. Review indicated Resident #18 was admitted on 7/2/13 and diagnoses, included but were not limited to, "...peripheral neuropathy, coronary artery disease, congestive heart failure, depression and insomnia...."</p> <p>The Level II Mental Health Assessment, completed on 9/30/10, indicated the resident has a diagnosis of primary insomnia.</p> <p>The social service progress note, dated 7/10/13, indicated "...the Resident is also on Ambien (Hypnotic) 2.5 mg (milligram)...."</p> <p>The physician progress note, dated 2/3/14, indicated "...the resident has nervousness and depression with insomnia. Will continue with current medications and treatments...."</p> <p>A physician order, dated 2/17/14, indicated discontinue Ambien at HS (hours sleep).</p> <p>A nurse's note, dated 2/17/14, indicated "...Ambien at HS discontinued...."</p>		<p><u>corrective action will be taken?</u> All residents on psychoactive medications will have had their care plans reviewed and revised to reflect any changed in medications effective 3-20-14. <u>What measures will be put into place to ensure this practice does not recur?</u> 1. Hubbard Hill Care Plan policy will be reviewed effective 3-20-14. 2. The nurse on duty will update care plans with new orders and change of condition 3. Nurses, Social Services and Activities have been educated on updating care plans effective 3-20-14 4. All physician's orders will be reviewed daily on scheduled days of work by the MDS nurse. 5. The MDS nurse will bring the Care Plan books to the clinical meeting daily and assure the new orders are addressed on the care plans of each individual resident. 6. The MDS nurse will audit 5 non-assigned residents to assure care plans are updated. The MDS audits will be weekly x 4, bi-monthly x 2, then quarterly. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the MDS nurse audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management, and quarterly at the QA meeting x 2. At that time will review for</p>				

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	<p>After an interview on 2/20/14 at 12:10 P.M., the Social Service Director (Employee #33) confirmed the lack of a care plan for insomnia for Resident #18, a care plan was presented on 02/20/14 at 1:30 P.M. for insomnia and potential side effects related to psychoactive medications. Employee #33 indicated the care plans had been located in the overflow file and had been thinned from the resident's care plan charting.</p> <p>On 2/20/14 at 3:05 P.M., an interview with LPN #34 indicated, that the care plan for sleep pattern disturbance should not have been thinned from the care plan book and should have been revised when the hypnotic medication was discontinued on 2/17/14.</p> <p>On 2/20/14 at 3:15 P.M., review of the sleep pattern disturbance care plan, completed on 12/20/13 with no revision date, indicated the problem: Sleep pattern disturbance related to long term dependency on hypnotics as evidenced by: difficulty falling or remaining asleep, complaints of sleepiness and waking earlier than desired. Interventions included but were not limited to "...8. Administer</p>		continued need for auditing. --				

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F000282 SS=D	<p>hypnotics as ordered...."</p> <p>On 2/21/14 at 10:00 A.M., record review of the current policy titled "Care Plan" received from the Director of Nursing indicated "...5. Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interviews, the facility failed to ensure the care plan</p>	F000282	<p><u>What corrective action will be done by the facility?</u> Resident#23's behavior tracking form has been updated to include</p>	03/25/2014			

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	<p>interventions were followed for mood monitoring for 1 of 1 residents reviewed for Hospice care (Resident #23) and behavior monitoring needs for 1 of 5 residents reviewed for unnecessary medications. (Resident #33) In addition, the facility failed to ensure the care plan interventions for toileting needs for 1 of 1 residents reviewed for incontinence needs. (Resident #105)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #23 was reviewed on 02/19/14 at 2:00 P.M. Resident #23 was admitted to the facility on 04/21/13 with diagnoses, including but not limited to: infectious enteritis, debility, coronary artery disease with graft, end stage diastolic congestive heart failure, chronic obstructive airway obstruction, depressive disorder, hypertension, osteoarthritis, generalize pain, convulsions, history of hip fracture, esophageal reflux, and hypothyroidism, chronic obstructive pulmonary disease. Resident #23 had been placed on Hospice care related to end stage congestive heart failure on 05/06/13.</p> <p>On 2/19/14 at 2:45 P.M., Resident</p>		<p>"tearful/crying" as a target behavior. Resident #33 had a Depakote reduction October 2013 routine Ativan reduction November 2013, and PRN Ativan reduction December 2013 per GDR guidelines. Resident #105 has completed a three day patterning for toileting and careplan has been updated to include toileting upon rising, before and after meals, and prior to bed. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Allresidents on behavior tracking will have appropriate interventions present on their behavior forms effective 3-21-14. Pharmacist will review all residents' medical records on 3-21-14 specifically focusing on residents receiving antipsychotics/hypnotics to assure a Gradual Dose Reduction has been attempted per regulations or that there is documentation that it is contraindicated. All incontinent residents will have completed a three day pattern for toileting by 3-21-14. Each will be placed on a toileting schedule to best fit their individual needs. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>1.Nursing staff and Social Services to be inserviced regarding policy and procedure related to behavior monitoring</p>		

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	<p>#23 was observed in her room, lying in her bed. Resident #23 was noted to be sitting up in her bed, dressed in a nightgown, had oxygen tubing in her nares, and was wearing glasses. Resident #23 after explaining how hard of hearing she was, proceeded to become very tearful and exclaimed she just wished she could die. She repeated wishing she could die several times. She also indicated she hurt "from her head to her toes." She then said "If I have to be here, I just wish I could die." LPN #24 was notified of the resident's tearfulness, pain, and statements about wanting to die, on 02/19/14 at 3:00 P.M. The LPN indicated this was "normal" for the resident but she was easily distracted with conversations about books and boats. The LPN also indicated she could offer Resident #23 pain medications but she usually refused the pain medications because she did not believe in taking them.</p> <p>On 2/12/14 at 10:00 A.M., Resident #23 was observed seated in her bed awake. She indicated her breakfast was okay but it was the same thing every morning. She then started crying and indicated she was just tired of living and wished it would end. She indicated she loved to</p>		<p>effective 3-20-14.</p> <p>2.Social Services to continue to complete Behavior Tracking forms monthly to assure appropriate interventions are in place and Care Plans are updated if needed.</p> <p>3.Nursing Unit Managers to audit Behavior tracking forms monthly to assure appropriate interventions are in place.</p> <p>4.Behavior Monitoring Meeting to continue to be held monthly to assure documentation is appropriate.</p> <p>5.Pharmacist to continue to review every resident's drug regimen every month including all residents receiving psychotropic medications.</p> <p>6.Behavior Monitoring Meeting to continue to be held monthly to reviewall residents receiving psychotropic medications. During this review, residents requiring a Gradual Dose Reduction will be addressed.</p> <p>7.Nursing staff to be inserviced regarding process for bowel and bladder assessment effective 3-20-14.</p> <p>8. Upon admission, the admission nurse to initiate three day pattern for toileting.</p> <p>9.MDS nurse to initiate three day patterning if indicated on the bowel and bladder assessment and update Care Plans stating such.</p> <p>10.Nursing Unit Managers to audit all residents on three day patterning to assure completion</p>				

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	<p>read and would brighten when discussing her books and her family. She told stories about her life but then would become very tearful.</p> <p>A review of an Minimum Data Set (MDS) assessment, completed on 05/16/13 due to a significant change in Resident #23's condition, indicated she had scored a "9" on the mood indicator section of the assessment. The assessment indicated nearly every day of the evaluation period the resident had trouble falling or staying asleep, sleeping too much, had felt tired, had little energy, and had a poor appetite.</p> <p>A subsequent quarterly MDS review assessment, completed on 01/23/14, indicated the resident's score for the mood indicator section of the assessment had increased to a score of "15." The resident indicated she felt down and had thoughts she would be better off dead, as well as the previously assessed mood indicators, on nearly all of the evaluation days.</p> <p>A care plan related to depression, initiated on 04/21/13, included interventions to provide medications as ordered, monitor for possible side</p>		<p>daily on scheduled days of work. _ _ <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>Behavior management meeting minutes will be reviewed monthly with the Director of Nursing/Director of Quality Management to assure reductions are done as necessary and target behaviors are documented as necessary. The minutes will then be brought to QA for review quarterly. Results of the Nursing Unit Managers audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p> <p>-</p>		

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	<p>effects from medication every shift using side effect monitoring flow sheet, monitor lab work as ordered, notify physician if side effects are noted or there is an increase in symptoms such as changes in sleep patten, lack of appetite, mood changes, decreased interest in activity, or an increase in anxiety, monitor for safety related to possible side effects from medication, and increase Cymbalta (an antidepressant) 60 mg (milligrams) to BID (twice a day).</p> <p>On 02/19/14 at 9:00 A.M., a review of form titled "Monthly Behavior Monitoring Flowsheet" for February 2014 indicated, "0" was written in the target behavior section of the form and the remaining form was blank. An interview with Employee #25, the Social Service Designee, on 02/21/14 at 11:45 A.M., indicated if a resident had not displayed any behaviors in a three month interval, the facility stopped monitoring for behavioral issues and monitored for side effects of medications. When queried as to the policy and procedure of a resident's mood who had declined significantly, according to the MDS assessments mood indicator score. Employee #25 indicated she was not sure if there</p>			

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	<p>was a policy. She further indicated she would note the decline in the Quarterly Social Service progress notes and nursing would document the issues in the nursing notes.</p> <p>A review of the 01/17/14 Quarterly Progress note for Resident #23 indicated Resident #23's mood score was "15." The resident's score indicated "moderately severe depression" The note further indicated the resident "varies between pleasant, cooperative and verbally combative with the staff." There was no note about her increased depressed mood or any note about her tearfulness.</p> <p>An interview with Social Service Designee (SDD), Employee #25, on 02/21/14 at 11:25 A.M., indicated besides the Behavior Assessment and Monitoring policy and procedure, there was no other policy regarding documentation and tracking of mood and/or behavior issues. She further indicated nurses were to document any "behaviors" and SSD could then initiate the behavior monitoring tracking form.</p> <p>The nursing notes, from 01/17/14 - 01/21/14 indicated the resident's emotional state was only noted</p>				

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	<p>once, on 01/20/14, as "can be tearful at times." There was no indication the resident's "normal" behavior of crying and stating she wished to die was documented or monitored in the nursing notes, on the behavior monitoring flow sheets, or in the social service notes. In addition, there was no indication Hospice or the resident's physician was made aware of the resident's increase in depressive mood indicators.</p> <p>2. The clinical record for Resident #105 was reviewed on 02/19/14 at 10:00 A.M. Resident #105 was admitted to the facility on 09/25/13 from the Assisted living side of the facility with diagnoses, including but not limited to: congestive heart failure, edema of the legs, athlerosclerosis heart disease, non insulin dependent diabetes mellitus, and "normal aging."</p> <p>The admission MDS (minimum data set) assessment for Resident #105, completed on 10/06/13, indicated the resident was frequently incontinent of her bladder. A subsequent MDS assessment, completed on 12/26/13, indicated the resident had declined and was now completely incontinent of her</p>						

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	<p>bladder.</p> <p>A bladder elimination assessment, completed on 09/25/13, indicated the resident could not control stopping her urine stream, and leaked or dribbled urine after urinating. Written at the bottom of the form was "resident is incontinent of bladder."</p> <p>The health care plan for the potential for skin breakdown related to immobility and incontinence, initiated on 10/18/13, and revised on 12/03/13, included the following interventions regarding toileting: "1. Observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. 2. Offer to toilet, check for incontinence before and after meals, at HS, on request and PRN. 3. Provide urinal/bedpan/bedside commode...."</p> <p>Resident #105 was observed, on 02/19/14 at 1:59 P.M. in her bed on concave mattress with matt on floor beside bed. The resident was awake and had her feet propped up on pillows. Her room smelled slightly of a stale urine odor and the door to bathroom was closed.</p> <p>On 2/20/14 at 9:00 A.M., the</p>						

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	<p>Resident #105 was observed to have been in her wheelchair and taken to the dining room for breakfast at 9:00 A.M. Resident #105 was pushed in her wheelchair to her room from the dining room by CNA #36 on 02/20/14 at 9:29 A.M. The resident was positioned in her room, the television was turned on for her, and her call light was placed within her reach. No toileting care was noted to be done.</p> <p>Resident #105 was observed in her room seated in her wheelchair on 02/20/14 at 9:56 A.M. She was in the same position and had not been toileted or received any care.</p> <p>Resident #105 was pushed by Activity staff member, Employee #37, to the dining room for Exercises activity on 02/20/14 at 10:13 A.M.</p> <p>Resident #105 was observed, on 02/20/14 at 10:45 A.M., still in the main dining room with the activity department. The exercise activity had ended and a newspaper was being read to them.</p> <p>Resident #105 was not noted to be in her room on 02/20/14 at 11:25 A.M., Interview with CNA #38, on 02/20/14 at 11:25 A.M., who was on</p>				

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	<p>the hall at the time, indicated the resident was still in the dining room at activities.</p> <p>Resident #105 was observed, on 02/20/14 at 11:30 A.M. seated in her wheelchair in the health care dining room. She indicated she had enjoyed activities and had been pushed from the side of the dining room used for activities directly to the dining room table. She was not provided any toileting care.</p> <p>Resident #105 was pushed from the dining room in her wheelchair to her room on 02/20/14 at 1:00 P.M. The resident was left in her wheelchair and was given a call light.</p> <p>Resident #105 was observed to put on her call light on 02/20/14 at 1:03 P.M. CNA #35 answered the call light and indicated the resident's hands had fallen to her lap and had accidentally put on her call light on. CNA #35 left the room and did not provide care other than checking with the resident and turning off the call light.</p> <p>During an interview, on 02/19/14 at 3:10 P.M., CNA #39 indicated Resident #105 was very dependent for care but could stand to help</p>			
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	<p>transfer from her bed to the wheelchair and/or wheelchair to the toilet. She further indicated the resident wore briefs and was usually incontinent of her bladder. She explained the resident was to be toileted every 2 hours. The CNA usually accomplished this by toileting the resident upon rising, before/after breakfast and lunch when she worked the day shift, before/after supper when she worked evenings.</p> <p>3. During an observation on 02/19/14 at 8:42 A.M., Resident #33 was observed sitting in his wheelchair with his eyes closed, uniboots on, sitting by wall at nurse's station.</p> <p>During an observation on 02/20/14 at 9:30 A.M., Resident #33 was observed with his eyes closed, breathing heavily and sitting in his w/c (wheelchair) at nurse's station.</p> <p>During an observation on 02/20/14 at 10:13 A.M. with CNA#12. Resident #33 was observed with both of his eyes closed, sitting by nurse's station in his w/c. CNA#12 approached Resident #33 in a soft voice, explained to him that he it</p>				

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	<p>was time for his oral care and was it ok to go back to his room. The resident was observed to opened both of his eyes, then shut them.</p> <p>During an interviewed on 02/18/14 at 8:45 A.M., CNA #18 indicated resident does not talk, and had a companion everyday from 10-l pm and then 4-7 pm.</p> <p>During an interview on 02/18/14 at 1:26 P.M., companion #20, indicated resident did not talk anymore. Companion #20 indicated she would usually talk and read to him.</p> <p>During interview with on 02/20/14 at 10:13 A.M., companion #14 indicated, she was usually with resident from 10 am-1 pm. and staff took him for breakfast.</p> <p>During an interview on 02/21/14 at 9:51 A.M., LPN#13, indicated a zero with line through it, on target behavior flowsheet, symbolized the resident didn't have any behaviors. She indicated she had not seen any behaviors in long time. She also indicated the medications, Depakote (mood stabilizer) and Ativan (an antianxiety), were given to the resident for behaviors of hitting</p>						

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	<p>another resident, scratching, and acting out.</p> <p>Resident #33's clinical record was reviewed on 02/20/14 at 9:48 A.M. The resident's diagnoses included, but were not limited to: dementia with behavior dist (disturbance), Alzheimer's disease, mood disorder, adjustment disorder with depression, depressive disorder, psychosis NOS (not specific), and HTN (hypertension).</p> <p>The quarterly MDS (Minimum Data Set) Assessment, dated 10/24/13, indicated the resident was uninterviewable. The BIMS (Basic Interview Mental Status) score indicated the resident was rarely/never understood. The resident required a person assist will ADL (Activities of Daily Living) care.</p> <p>The MAR (Medication Administration Sheet) for February 2014 indicated the following: Divalproex (Depakote) cap 125 MG (Milligrams), take 2 capsules by mouth (250 MG) daily at bedtime on Monday. Divalproex cap 125 MG take 2 capsule by mouth (250 MG) twice day on Tuesday, on Wednesday, on Thursday, on Friday, on Saturday, on Sunday; Lorazepam (Ativan) tab 0.5 mg take</p>			

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	<p>1 tablet by mouth twice daily.</p> <p>The Social Services Notes indicated the following: "dated 01/10/14 Quarterly Assessment:No medical or behavioral changes are reported in this quarter.... 10/25/13 Quarterly Review:There is no medical or behavioral change reported by nursing staff, companion or guardian at this time.... 08/05/13 Annual Assessment Note....Res(resident) has a hx(history) of being combative and resistive to care. No episodes recorded during this assessment period... 05/10/13 Quarterly Assessment Note....No episodes recorded during this assessment period...."</p> <p>The care plans were as follows: The problem originally dated 04/19/12, was decrease Depakote sprinkles from 250 mg BID to 125 mg BID; 05/16/12 V.O.(verbal order) Ativan 0.5 mg 1 or 2 tab po every 6 hours; 06/28/12 PRN (as needed)(DC X 1 WK after 5-24-12; 06/14/12 Depakote started 250 mg BID; 11/13/13 drug reduction attempt decrease Ativan. The goal was the resident, would not injure himself or others. The interventions included: If resident is beginning to resist care,</p>				

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	<p>try approaching again at a later time, Try another caregiver, if possible, explain to the resident everything you are about to do, before you initiate it, give positive reinforcement for compliance, inform guardian and physician when the resident becomes combative, start a behavior tracking sheet if resident became combative and psychiatric follow-up if ordered.</p> <p>On 02/20/14 at 3:00 P.M., the Director of Management Quality provided a current policy titled "Behavior Assessment and Monitoring, Scope: Nursing-Social Services". The policy indicated the following "...PURPOSE: 1) Problematic behavior will be identified and managed appropriately. 2) Residents will have minimal complications associated with the management of problematic behavior. 3) The facility will comply with regulatory requirements related to the use of medications to manage problematic behavior. General Guidelines: Assessment...Management: The staff will identify and discuss with the practitioner situations where non-pharmacological approaches are indicated, and will institute such measures to the extent possible.</p>			

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	<p>Monitoring: If the resident is being treated for problematic behavior or mood, nursing or social services will initiate the Monthly Behavior Monitoring Flowsheet.Social Services will update Behavior Forms monthly with appropriate non-pharmaceutical interventions. The nursing staff will document each shift....Social Services will review monthly. Three month of no behaviors will warrant a review for possible medication reduction, unless contraindicated"</p> <p>3.1-35(g)(2)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interviews, the facility failed to ensure the use of a specific pressure relieving device to promote healing of pressure. For 1 of 2 residents reviewed in a sample of 2. (Resident #57)</p> <p>Finding includes:</p> <p>During an observation on 02/19/14 at 2:10 P.M., Resident #57 was sitting at end of hall in w/c (wheelchair) on gel cushion, with eyes closed, while room was being cleaned.</p> <p>During an observation on 02/20/14 at 11:00 A.M., Resident #57 was sitting up in w/c on gel cushion in room.</p> <p>During an observation on 02/20/14</p>	F000314	<p><u>What corrective action will be done by the facility?</u> Resident#57's pressure area is healed effective March 6, 2014. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents with pressure areas or the potential for pressure areas will be audited and pressure reducing cushions placed in their chair as needed effective 3-20-14. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>1.On admission, residents will be assessed using the Braden Scale for need of pressure relieving cushion.</p> <p>2.CNA assignment sheets will be updated as needed with pressure relieving cushion listed for each resident with a pressure area or with the potential for skin breakdown and will be made available to therapy staff.</p>	03/25/2014	

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	<p>at 2:42 P.M., Resident #57 was sitting in w/c, on gel cushion, in room talking with a visitor.</p> <p>During an observation on 02/21/14 at 8:42 A.M., Resident #57 was sitting in w/c, on gel cushion, in dinning room finishing up breakfast.</p> <p>During an observation on 02/21/14 at 8:56 A.M., Resident #57 was self propelling with feet in w/c, on gel cushion, back to room down green hallway.</p> <p>During an observation on 02/21/14 at 9:29 A.M., Resident #57 was sitting in w/c, on gel cushion, in room with eyes closed.</p> <p>During an observation on 02/21/14 at 9:39 A.M., PTA (Physical Therapy Aide) #15, providing electrical stimulus to treat for left knee pain to Resident #57. PTA #15 using gait belt, transferred resident with pivoting technique, into resident's recliner chair. No cushion was observed during transfer of resident into chair. PTA #15 indicated that she should have placed a cushion in chair, before resident was transferred.</p> <p>The clinical record for Resident #57</p>		<p>3. During weekly skin assessments, the nurse will assess for the need of a pressure relieving cushion.</p> <p>4. Unit managers to audit daily x2 weeks, weekly x4 weeks, then monthly on scheduled days of work to ensure each resident requiring a pressure relieving cushion has one in place.</p> <p>5. Therapy manager or designee to audit three residents following therapy to assure a pressure relieving cushion is under the resident if indicated weekly x4, bi-monthly x2 months, then quarterly. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Nursing Unit Managers audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management, and quarterly at the QA meeting x2. Results of the therapy audit will be reviewed monthly at the therapy meeting, and quarterly at the QA meeting x2. At that time will review for continued need for auditing.</p>				

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	<p>was reviewed on 02/19/14 at 1:50 P.M., and indicated the following: "Weekly Skin Assessment Sheet," dated 12/30/13: left gluteal fold 4 X 2.7 cm (centimeters), not open, dark purple in color surrounded by nonblanchable red area. Doctor and family notified, TAP/shift position every 2 hrs (hours). Use positioning devices as needed.</p> <p>The "AT RISK" FOR PRESSURE SORE DEVELOPMENT, dated 12/31/13, indicated the following: the interventions were the following: Monitor comfort, specialized mattress: low air mattress, specialized pressure reduction cushion on w/c(wheelchair): roho (seating device used for pressure distribution)....</p> <p>On 02/21/14 at 8:53 A.M., a review of a form titled" WEEKLY PRESSURE ULCER RECORD " indicated the following: 02/20/14 stage: US (Unstagable) 0.8 X 0.9 cm(centimeters), depth UD(un determined), no exudate (drainage), tunneling, or odor. 50 %granulation(new growth of tissue) 50 % slough (dead tissue), 1 cm pink blanchable surrounding skin color. Response to treatment/comment: pain when sits</p>			

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	<p>on it to long. Res.(Resident) reminded to change position when offered. also important to call if she feels any pain so staff can assist in reposition. Preventive measures/progress indicated the following: turn every 2 hours &(and) PRN (as needed). Pressure relieving interventions indicated: roho (pressure relief cushion) and low air loss mattress.</p> <p>On 02/20/14 at 3:00 pm, the Director of Quality Manager, provided the Skin breakdown prevention protocol: Use of Braden Scale Tool, and indicated this document was current. The skin breakdown prevention protocol indicated the following: Upon admission, quarterly ...4. The managers on each unit will review the assessments and interventions for appropriateness and compliance.</p> <p>During an interview and observation on 02/21/14 at 10:10 A.M., Unit manager #10, indicated the resident had a gel cushion on her W/C seat and not a roho cushion. She also indicated this resident was to have a roho cushion not a gel cushion, and she did not know if it had been ordered.</p> <p>3.1-40(a)(2)</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, record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for a decline a bladder continency received a thorough assessment and individualized interventions to restore as much bladder continency as possible. (Resident #105) In addition, the facility failed to ensure 1 of 1 residents observed for indwelling urinary catheter care</p>	F000315	<p><u>What corrective action will be done by the facility?</u> Resident #105 has completed three a day patterning for toileting and care plan has been updated to include toileting upon rising, before and after meals, and prior to bed. Resident #80 continues with an indwelling catheter for the diagnosis of obstruction. She currently is free of signs and symptoms of a UTI. <u>How will the facility identify other residents</u></p>	03/25/2014

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	<p>received appropriate care and service to prevent urinary tract infections. (Resident #80)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #105 was reviewed on 02/19/14 at 10:00 A.M. Resident #105 was admitted to the facility on 09/25/13 from the Assisted living side of the facility with diagnoses, including but not limited to: congestive heart failure, edema of the legs, arteriosclerosis heart disease, non insulin dependent diabetes mellitus, and "normal aging."</p> <p>The admission MDS (minimum data set) assessment for Resident #105, completed on 10/06/13, indicated the resident was frequently incontinent of her bladder. A subsequent MDS assessment, completed on 12/26/13, indicated the resident had declined and was now completely incontinent of her bladder.</p> <p>A bladder elimination assessment, completed on 09/25/13, indicated the resident could not control stopping her urine stream, and leaked or dribbled urine after urinating. Written at the bottom of</p>		<p><u>having the potential to be affected by the same practice and what corrective action will be taken?</u> All incontinent residents will have completed a three day pattern for toileting by 3-21-14. . Each will be placed on a toileting schedule to best fit their individual needs. All residents with catheters have been assessed and reviewed by the physician to assure there is a need for such and a proper diagnosis is in place. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>1.Nursing staff to be inserviced regarding process for bowel and bladder assessment effective 3-20-14.</p> <p>2.Nursing staff to be inserviced regarding policy and procedure for catheter care effective 3-20-14.</p> <p>3.Upon admission, the admission nurse to initiate three day pattern for toileting.</p> <p>4.MDS nurse to initiate three day patterning if indicated on the bowel and bladder assessment and update Care Plan if indicated.</p> <p>5.Nursing Unit Managers to audit all residents on three day patterning to assure completion daily on scheduled days of work.</p> <p>6.Nursing unit managers to audit residents with catheters daily on their scheduled days of work, to assure catheter is appropriately covered when out of their room and tubing is properly placed.</p>		

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	<p>the form was "resident is incontinent of bladder." The portion of the assessment to indicate when the resident leaked urine, how long she had experienced the problems, her normal elimination times and habits was not completed. The "bladder status" portion of the survey was left incomplete. Instructions on the form indicated the following: "proceed to the '3- day pattern' bowel and bladder monitoring record if an incontinence problem is identified on admission, or newly identified." There was no bowel and bladder monitoring record completed for the 09/25/13 incontinence assessment.</p> <p>A bladder elimination assessment, completed on 12/23/13, indicated the resident sometimes leaked or dribbled after urination, when coughing, sneezing, laughing, and exercising, and if she delayed going to the toilet. "Unaware" was written in the portion of the assessment to indicate how often the resident usually urinated during the day and night. There were other assessment questions on the form which were not completed. The resident was indicated as "Incontinent - has inadequate control of bladder, multiple daily episodes." The form included instructions to proceed to a</p>		<p><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of both Unit Manager audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p> <p>-</p>		

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	<p>3-day pattern record. There was no bowel and bladder monitoring record completed for the 12/23/13 assessment.</p> <p>The health care plan for the potential for skin breakdown related to immobility and incontinence, initiated on 10/18/13, and revised on 12/03/13, included the following interventions regard toileting: "1. Observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. 2. Offer to toilet, check for incontinence before and after meals, at HS, on request and PRN. 3. Provide urinal/bedpan/bedside commode...."</p> <p>Resident #105 was observed, on 02/19/14 at 1:59 P.M. in her bed on concave mattress with matt on floor beside bed. The resident was awake and had her feet propped up on pillows. Her room smelled slightly of a stale urine odor and the door to bathroom was closed.</p> <p>On 02/20/14 at 8:41 A.M., Resident #105 was observed transported by wheelchair to the dining room for breakfast at 9:00 A.M. Resident #105 was pushed to her room from the dining room by CNA #36 on 02/20/14 at 9:29 A.M. She was</p>						

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	<p>positioned in her room, in her wheelchair, the television was turned on for her, and her call light was placed in her reach. No toileting care was noted to be done.</p> <p>Resident #105 was observed in her wheelchair, in her room on 02/20/14 at 9:56 A.M. She was in the same position and had not been toileted or received any care.</p> <p>Resident #105 was pushed by Activity staff member, Employee #37, to the dining room for Exercise activity on 02/20/14 at 10:13 A.M.</p> <p>Resident #105 was observed, on 02/20/14 at 10:45 A.M., still in the main dining room with the activity department. The exercise activity had ended and a newspaper was being read by the staff to the residents in the area.</p> <p>Resident #105 was not noted to be in her room on 02/20/14 at 11:25 A.M., An interview with CNA #38, on 02/20/14 at 11:25 A.M., who was on the hall at the time, indicated the resident was still in the dining room at activities.</p> <p>Resident #105 was observed, on 02/20/14 at 11:30 A.M. seated in her</p>				

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	<p>wheelchair in the health care dining room. She indicated she had enjoyed activities and had been pushed from the side of the dining room used for activities directly to the dining room table. She was not provided any toileting care.</p> <p>Resident #105 was pushed from the dining room in her wheelchair to her room on 02/20/14 at 1:00 P.M. The resident was left in her wheelchair and was given a call light.</p> <p>Resident #105 was observed to put on call light on 02/20/14 at 1:03 P.M. CNA #35 answered the call light and indicated the resident's hands had fallen to her lap and accidentally put on her call light. CNA #35 left the room and did not provide any care other than checking with the resident and turning off the call light.</p> <p>Interview, on 02/19/14 at 3:10 P.M., with CNA #39 indicated Resident #105 was very dependent for care but could stand to help transfer from her bed to the wheelchair and/or wheelchair to the toilet. She indicated the resident wore briefs and was usually incontinent of her bladder. She indicated the resident was to be toileted every 2 hours and she usually accomplished this by</p>						

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	<p>toileting the resident upon rising, before and after breakfast and lunch when she worked the day shift, before and after supper when she worked evenings.</p> <p>During an interview on 02/20/14 at 9:30 A.M., the MDS coordinator indicated nurses completed a bladder incontinence assessment on admission. She further indicated she reviewed the assessments and if there were any changes with subsequent MDS quarterly assessments, the assessment "goes back to the nurse." She indicated the nurses do not necessarily reassess the incontinence and she was not aware of any patterning for incontinence completed for residents. The MDS coordinator was aware of what patterning incontinence was and indicated she did not think the facility utilized patterning. She indicated the CNAs did document toileting on the ADL records.</p> <p>An interview with the Director of Nursing, on 02/21/13 at 11:00 A.M. confirmed there was no bladder incontinence patterning record completed for Resident #105. She indicated the facility had no policy and procedure regarding the bladder</p>						

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	<p>incontinence assessment other than the assessment form and the bowel and bladder 3-day pattern form. The facility's assessment form did not assess any current signs and symptoms of a urinary tract infection, did not include an evaluation of potential diagnosis and/or medications on the resident's incontinence, and did not evaluate any environmental changes which might have affected the resident's continence.</p> <p>2. On 2/17/14 at 12:20 P.M., Resident #80 was observed with indwelling catheter tubing lying on the floor draped back up to catheter bag. The urine in the catheter tubing noted to be cloudy, pale yellow with sediment. At 12:57 the resident was observed wheeling self out of the dining room, past CNA #4 and CNA #2 neither CNA addressed the tubing dragging on the floor.</p> <p>On 2/17/14 at 3:25 P.M., Resident #80 was observed in activities with indwelling catheter tubing dragging on the ground.</p> <p>On 2/18/14 at 9:22 A.M., Resident #80 was observed being pushed by RN #7 to room with the indwelling catheter tubing dragging on the</p>			

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	<p>ground.</p> <p>On 2/18/14 at 11:55 A.M., Resident #80 was observed wheeling herself to Healthcare dining room with indwelling catheter tubing dragging on the floor.</p> <p>On 2/19/14 at 8:50 A.M., Resident #80 was observed in the healthcare dining room, with the indwelling catheter tubing lying on floor.</p> <p>On 2/19/14 at 8:56 A.M., Resident #80 was observed being pushed in her wheelchair back to her room by LPN #23, the indwelling catheter tubing was dragging on floor.</p> <p>On 2/19/14 at 10:30 A.M., review of undated policy titled "Urinary Catheters" indicated there were no specific policy or procedure describing the exact manner of how indwelling foley catheter tubing should be positioned.</p> <p>On 2/19/14 at 11:50 A.M., Resident #80 was observed being pushed in wheel chair into the dining room by the Activity Director #3, the indwelling catheter tubing was dragging on floor.</p> <p>During an interview, on 2/19/14 at</p>						

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	<p>2:03 P.M., CNA #22 indicated, the catheter should be in a dignity bag and the tubing should be coiled up and placed in the bag</p> <p>On 2/19/14 at 3:15 P.M., Resident #80 was observed in a wheel chair in her room, the indwelling catheter tubing was resting on the floor and contained cloudy yellow sediment floating in the tubing.</p> <p>3.2-41(a)(2)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident was free from unnecessary medication, and to provide adequate monitoring and indication for use in 1 of 5 residents reviewed for unnecessary medications. (Resident #33)</p> <p>Findings include:</p> <p>During an observation on 02/19/14 at 8:42 A.M., Resident #33 was</p>	F000329	<p><u>What corrective action will be done by the facility?</u> Resident#33 had a drug reduction of Depakote in October 2013, routine Ativan in November 2013 and PRN Ativan in December 2013 as outlined in his Physician's orders. Resident #33's behavior tracking form has been updated to include target behaviors. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Pharmacist to review all residents' medical records</p>	03/25/2014	

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	<p>observed sitting in his wheelchair with his eyes closed, sitting by wall at nurse's station</p> <p>During an observation on 02/20/14 at 9:30 A.M., Resident #33 was observed with his eyes closed and breathing heavily and sitting in his w/c (wheelchair) at nurse's station.</p> <p>During an observation on 02/20/14 at 10:13 A.M., Resident #33 was sitting by nurse's station in his w/c with his eyes closed. CNA#12 approached Resident #33 in a soft voice explained to him that he it was time for his oral care and was it ok to go back to his room. Observed resident opened both of his eyes then shut them both.</p> <p>During an interviewed on 02/18/14 at 8:45 A.M., CNA #18, indicated resident did not talk, he had a companion everyday from 10-l pm and then 4-7 pm.</p> <p>During an interview on 02/18/14 at 1:26 P.M., companion #20, indicated he did not talk anymore. She indicated she would usually talk and read to the resident.</p> <p>During an interview on 02/20/14 at 10:13 A.M., companion #14</p>		<p>effective 3-21-14 specifically focusing on residents receiving antipsychotics/hypnotics to assure a Gradual Dose Reduction has been attempted per regulations or that there is documentation that it is contraindicated. All residents on behavior tracking will have appropriate interventions present on their behavior forms effective 3-21-14. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>1.Nursing staff and Social Services to be inserviced regarding policy and procedure related to behavior monitoring effective 3-20-14.</p> <p>2.Pharmacist and Social Services to continue to review every resident's drug regimen every month including all residents receiving psychotropic medications.</p> <p>3.Behavior Monitoring Meeting that includes the pharmacist to continue to be held monthly to review all residents receiving psychotropic medications. During this review, residents requiring a Gradual Dose Reduction will be addressed and physician to be notified of recommendation.</p> <p>4.Social Services to audit the residents on psychotropic medications monthly to assure all physician follow-up is documented according to regulations regarding Gradual Dose Reduction.</p> <p>5.Social Services to continue to</p>				

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	<p>indicated she was usually with resident from 10 am-1 pm. Staff took him for breakfast.</p> <p>During an interview on 02/20/14 at 3:05 P.M., Unit Manager #10 indicated, the guardian thought the resident did better on the Ativan (an antianxiety) for itching, because the resident did not what to do with his hands so he itches</p> <p>During an interview on 02/21/14 at 9:51 A.M., LPN #13 explained, a zero with line through it on the target behavior flowsheet, meant Resident #33 didn't have any behaviors. She indicated she had not seen any behaviors in long time. She also indicated that the medications, Depakote (mood stabilizer) and Ativan, were administered to the resident for behaviors of hitting another resident, scratching, and acting out.</p> <p>Resident #33's clinical record was reviewed on 02/20/14 at 9:48 A.M. The resident 's diagnoses included, but were not limited to: dementia with behavior dist (disturbance), Alzheimer's disease, mood disorder, adjustment disorder with depression, depressive disorder, psychosis NOS (not specific), and hypertension.</p>		<p>complete Behavior Tracking forms monthly to assure appropriate interventions are in place.</p> <p>6.Nursing Unit Managers to audit Behavior tracking forms monthly to assure appropriate interventions are in place. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Nursing Unit Managers audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing. Results of the Social Service audits will be reviewed at the monthly Behavior Meeting. The results will be given to the administrator and presented to QA meeting quarterly times 2. At that time will review for continued needfor auditing.</p>				

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	<p>The Medication Administration Sheet (MAR) for February 2014 indicated the following: Depakote (mood stabilizer) 125 mg. (Milligrams), take 2 capsules po (by mouth) daily at bedtime on Monday. Divalproex (Depakote) 125 mg., take 2 capsules po (250 MG) twice day on Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday; Ativan 0.5 mg po twice daily.</p> <p>The pharmacist reviewed the MAR for December, dated 12/17/13, and January, dated 01/23/14, with no recommendations for changes in medications.</p> <p>Resident's #33 physician orders indicated on 12/07/13 that Ativan 0.5 mg prn (as needed) and Ativan 1 mg. every pm were discontinued, and re-ordered on 12/23/13 Ativan 0.5 mg twice a day for anxiety.</p> <p>Nurse's Notes dated 12/07/13 at 2:40 pm indicated Ativan was discontinued for non-use. Reviewed Nurse's Notes from 12/10/13 through 02/12/14, indicated no information related to any behavior and/or anxiety.</p> <p>The Monthly Behavior monitoring</p>						

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	<p>Flowsheets for January 2014 indicated the following: Dementia with behavioral disturbance. Psychoactive medication: Ativan and Depakote. Target Behavior: documentation had a zero with a line through it. There had been behaviors noted for January 2014. Flowsheet for February 2014 indicated the following: Dementia with behavioral disturbance. Psychoactive medication: Ativan. Target Behavior: The documentation had a zero with a line through it. There had been no behaviors noted for February 2014.</p> <p>The Social Services Notes indicated the following: "dated 01/10/14 Quarterly Assessment:No medical or behavioral changes are reported in this quarter.... 10/25/13 Quarterly Review:There is no medical or behavioral change reported by nursing staff, companion or guardian at this time.... 08/05/13 Annual Assessment Note....Res (resident) has an hx (history) of being combative and resistive to care. No episodes recorded during this assessment period... 05/10/13 Quarterly Assessment Note....No episodes recorded during this assessment period...."</p>			

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	<p>The Quarterly "Care Plan Conference,"dated 10/31/13, indicated Nursing-Drug reduction once through a week. (Depakote). Labs are good. Care Plan Conference dated 10/10/12 indicated:Ativan added 0.25 MG BID for scratching.... "</p> <p>The quarterly MDS (Minimum Data Set) Assessment, dated 10/24/13, indicated the resident was un-interviewable. The resident's BIMS (Basic Interview Mental Status) indicated the resident rarely/never understood. The resident required one person assist will ADL (Activities of Daily Living) care.</p> <p>Resident #33 ' s MDS (Minimum Data Set) Assessment, dated 1-14-14, indicated the following: " Wandering Risk Assessment"- resident's mobility: Not able to walk alone, able to walk with walker or other assistive device or mobile in a wheelchair, able to walk with assistance of others. No history of wandering. Dementia. Resident currently taking medications that may cause confusion or disorientation.</p>			

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	<p>The Physician's Progress notes, dated 11/13/13, indicated the following: " Daytime caregiver reported resident seemed to be sleepier recently. The patient tolerated the medication without reported problems. The patient remained total care. He had had a Depakote dosage reduction. He was eating and taking in fluids well per nursing...."</p> <p>The Activities Quarterly Assessment on 01/17/14, indicated"....the caregivers will bring him to activities of interest, but he is passive with involvement...."</p> <p>The care plans were as follows: The problem originally dated 04/19/12, was decrease Depakote sprinkles from 250 mg BID to 125 mg BID; 05/16/12 V.O. (verbal order) Ativan 0.5 mg 1 or 2 tab po every 6 hours; 06/28/12 PRN (as needed) (DC [discontinue] X 1 WK [week] after 5-24-12; 06/14/12 Depakote started 250 mg BID; 11/13/13 drug reduction attempt decrease Ativan. The goal was the resident, would not injure himself or others. The interventions included: If resident was beginning to resist care, try approaching again at a later time,</p>			

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	<p>Try another caregiver, if possible, explain to the resident everything you are about to do, before you initiate it, give positive reinforcement for compliance, inform guardian and physician when the resident becomes combative, start a behavior tracking sheet if resident became combative and psychiatric follow-up if ordered.</p> <p>On 02/20/14 at 3:00 pm, the Director of Management Quality provided the policy " Behavior Assessment and Monitoring, Scope: Nursing-Social Services" and indicated this document is current. The policy indicated the following: "PURPOSE: 1) Problematic behavior will be identified and managed appropriately. 2) Residents will have minimal complications associated with the management of problematic behavior. 3) The facility will comply with regulatory requirements related to the use of medications to manage problematic behavior. General Guidelines: Assessment....Management: The staff will identify and discuss with the practitioner situations where non-pharmacological approaches are indicated, and will institute such measures to the extent possible. Monitoring: If the resident is being</p>				

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	<p>treated for problematic behavior or mood, nursing or social services will initiate the Monthly Behavior Monitoring Flowsheet.Social Services will update Behavior Forms monthly with appropriate non-pharmaceutical interventions. The nursing staff will document each shift....Social Services will review monthly. Three month of no behaviors will warrant a review for possible medication reduction, unless contraindicated"</p> <p>3.1-48(a)(6)</p>				

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview the facility failed to post the total number of the actual hours worked for registered nurses, licensed practical nurses and certified nurse aides.</p>	F000356	<p><u>What corrective action will be done by the facility?</u> The form "Daily Report of Nursing Staff Directly Responsible for Resident Care" has been posted with the accurate number of nursing hours worked. <u>How will the facility</u></p>	03/25/2014			

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	<p>Finding includes:</p> <p>On 2-17-14 at 1:35 P.M., a form titled "Daily Report of Nursing Staff Directly Responsible for Resident Care" located across from the main nursing station, on a bulletin board indicated, census for day shift on 2-17-14 was 58. The form omitted the total number and actual hours worked by the registered nurses (RN), licensed practical nurses (LPN) and certified nursing assistants (CNA).</p> <p>On 2-18-14 at 9:20 A.M., a form titled "Daily Report of Nursing Staff Directly Responsible for Resident Care" dated 2-18-14 was observed on the bulletin board. The form omitted the total number and actual hours worked by the RN's, LPN's and CNA's for each shift.</p> <p>On 2-19-14 at 3:20 A.M., the Daily Report of Nursing Staff Directly Responsible for Resident Care form was observed. The form dated 2-19-14, omitted the total number and actual hours worked by the RN's, LPN's and CNA's for each shift.</p> <p>On 2-21-14 at 9:25 A.M. a review of</p>		<p><u>identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> The form "Daily Report of Nursing Staff Directly Responsible for Resident Care" has been updated to include actual hours worked instead of number of shifts worked. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>1. Nursing staff will be inserviced on the proper documentation of nursing hours to be posted each shift effective 3-20-14.</p> <p>2. Night shift nurse to initiate form daily.</p> <p>3. 2200 Hall nurse to document actual nursing hours at the beginning of each shift.</p> <p>4. Health Care Unit Manager or charge nurse to audit form every day x2 weeks, weekly x4 weeks, then monthly on scheduled days of work to assure hours are documented appropriately. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Nursing Unit Managers audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>				

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	<p>2-17-14 thru 2-20-14 actual hours worked forms received from the Business Office Representative #21 indicated the actual hours worked was not posted or calculated until the following day.</p> <p>During an interview on 2-21-14 at 10:30 A.M. the Administrator indicated the Daily Report of Nursing Staff Directly Responsible for Resident Care was filled out by night nurse and posted prior to day shift. When asked about the actual hours worked, he indicated the business office would track that information the next day. The actual hours worked wasn't posted on the Daily Report of Nursing Staff Directly Responsible for Resident Care form, just the shift times.</p> <p>3.1-13(a)</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interviews, the facility failed to ensure food and equipment was stored under sanitary conditions. The facility also failed to prepare and serve food under sanitary conditions in one of one kitchens, two of two serveries, and two of four dining rooms. This potentially affected all 154 residents in the facility.</p> <p>Findings include:</p> <p>1. During the kitchen sanitation tour, conducted on 02/17/14 from 10:05 A.M. -10:35 A.M., the following was noted:</p> <p>There were 5 stacks of metal steam table pans with visible water dripping from both inside and outside of the pans, put away as clean across from the stove and by the prep area and food processor area on shelves.</p> <p>A plastic container with dry yeast</p>	F000371	<p><u>What corrective action will be done by the facility?</u> Hubbard Hill policy states that all pans are dried thoroughly prior to being stored. There are no scoops left in any containers. All food stored in the refrigerator is identified, properly labeled, dated and covered. Dietary staff to be trained on proper food handling, preparation and delivery effective 3-20-14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Dietician and dietary management team have randomly observed food handling, preparation and delivery in all dining areas. <u>What measures will be put into place to ensure this practice does not recur?</u> 1. Dietary Staff to be inserviced on proper food handling, preparation and delivery effective 3-20-14. 2. Dietary staff to be inserviced on proper handwashing effective 3-20-14. Procedure has been posted at handwashing stations. 3. Dietary manager or designee to audit food preparation in each</p>	03/25/2014			

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	<p>was noted by the pizza making supplies, with a scoop lying in the yeast.</p> <p>The prep refrigerator, located beneath the steam table, contained two plastic uncovered containers, containing breaded and unbreaded chicken tenders. There was food stored above open containers. In addition, there was an opened package of hot dogs with the meat exposed, uncovered and a package of uncovered hamburger patties. There were food items stored above all of the uncooked meat items.</p> <p>2. During observation of the food preparation, conducted on 02/17/14 between 11:40 A.M. - 12:00 P.M., the following was noted:</p> <p>Employee #9 was noted to be in the process of grinding 14 pieces of cooked chicken breasts. The employee was noted to hold the food processor blade with his bare hands after having touched the outside of the food processor, hot pads, and a pan containing the chicken breast. He repeated the process twice, holding the blade with his bare, contaminated hands.</p> <p>Employee #10 was observed</p>		<p>of the three dining rooms on scheduled days of work.</p> <p>4. Dietician to audit food handling, preparation and delivery weekly x4 weeks, bi-monthly x2, then quarterly on scheduled days of work to ensure proper technique.</p> <p>5. Dietary manager or designee to audit 5 staff members three times per week x 4 weeks, weekly x4 weeks, then monthly, on scheduled days of work to ensure proper handwashing. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Dietary Manager/Designee's audits to be reviewed bi-weekly in Dietary Meeting with Administrator and presented to QA meeting quarterly x 2. At that time will review for continued need for auditing.</p>		

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	<p>pureeing chicken breasts. She had on disposable gloves, and had handled a blender, the outside of the pan, a hot water faucet, ladles and spoon hands, and then touched the blade of the food processor with her contaminated gloved hands when she was transferring the meat from the blender into the food processor.</p> <p>3. During observation of the food service in the health care servery, conducted on 02/17/14 between 12:15 P.M. - 12:30 P.M., Cook #1 was noted to touch handles of scoops, paper menu orders, the refrigerator door, plates, and then handled grilled cheese sandwiches with her bare, contaminated hands as she cut them in half and put them onto plates to be served to residents in the health care dining room.</p> <p>During observation of the meal service in the rehabilitation servery, conducted on 02/19/14 at 11:30 A.M., Cook #1 was noted to wash her hands, put on disposable gloves, and then handled steam table pan lids, the oven door, the outside of the bread baggie, and then directly handled the submarine style buns with her contaminated, gloved hands. She was also noted to</p>				

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	<p>handle lettuce, tomatoes with the same contaminated gloved hands. In addition, she was noted to obtain a prepared bowl of tossed salad from the refrigerator, remove the plastic wrap, and then removed cucumbers from the salad with her contaminated gloved hands.</p> <p>4. On 2/17/14 at 11:48 A.M., Dietary Aide #30 was observed in the main dining room serving ice water to the resident's. The Dietary Aide was observed to rub her hand under her nose and around her eyes, then picked up a water pitcher and began pouring water into cups for the residents in the main The Dietary Aide was not observed to wash her hands or use hand gel before pouring the water into the cups.</p> <p>On 2/17/14 at 11:50 A.M., Dietary Aide #31 was observed reaching his arm across 3 water pitchers that did not have lids on them, the sleeve of his shirt was observed touching the inside of one of the water pitchers. The Dietary Aide then picked up the water pitcher that his sleeve touched and poured water into cups for the residents in the main dining room.</p> <p>On 2/20/14 at 11:40 A.M., an</p>				

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	<p>interview with Dietary Aide #30 indicated that she should wash her hands any time she touches food or after she takes off her gloves.</p> <p>On 2/20/14 at 1:15 P.M., record review of the current policy titled "Dining Services Policy and Procedure Manual. Sanitation and Safety. Handwashing" received from the Dietary Manager indicated "...Dining services staff is required to wash their hands in accordance with local and state health department regulations...To protect the public health from food borne illness...2. When to wash hands...D. After touching any part of your body...O. Any time you touch a resident or anything a resident has used...."</p> <p>5. On 2/17/14 at 11:55 A.M., wait staff #1 was observed holding grill cheese with her bare hands while cutting it, she then picked up half of sandwich with bare hands, placed it on plate. Wait staff #8 then served the sandwich to a resident.</p> <p>On 2/17/14 at 11:58 A.M., wait staff #1 was observed licking her first finger of right hand and fingering through the residents lunch orders. Wait staff #1 was observed holding</p>						

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	<p>a grilled cheese sandwich with her bare hands and placing sandwich on a plate. The plate was handed to wait staff #8 who was observed delivering the plate to the resident.</p> <p>On 2/17/14 at 12:06 P.M., wait staff #1 was observed holding grill cheese with bare her hands, placing half a sandwich on a plate. The plate was handed to wait staff #8 who served it to Resident #24 who proceeded to eat it.</p> <p>On 2/17/14 at 12:08 P.M., wait staff #1 was observed holding grill cheese sandwiches with her bare hands. Wait staff #1 picked up the sandwiches with her bare hands and placed them on the plates. She handed the plates to wait staff #8, who then served it to Residents #43 and #20.</p> <p>On 2/17/14 at 12:34 P.M., wait staff #8 was observed with her thumb in the bowl of blueberry cobbler while serving it to residents # 86 and #63.</p> <p>On 2/20/14 at 3:00 P.M., review of policy titled "Glove Use" dated 9/2008 indicated "... 2. Wear gloves any time you will be handling food that will receive no further cooking ...5. Change gloves anytime you</p>				

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	touch any item that has not been sanitized...8. Before beginning a different task...." 3.1-21(i)(2)			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to label medications with an open date and to dispose of expired</p>	F000431	<p><u>What corrective action will be done by the facility?</u> All expired medications and treatments have been destroyed per facility policy. All open medications requiring an</p>	03/25/2014			

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	<p>medications, lotions and ointments in 2 of 9 medication carts observed.</p> <p>Findings include:</p> <p>During an observation on 02/19/14 at 10:00 A.M., of the green hallway medication cart #1 with LPN #13, 2 Cleansing Body lotions had an expiration date of 12/2013. In medication cart #2 with LPN #13, 1 Cleansing Body Lotion had expired on 12/2013. LPN #13, indicated the lotion was used by current residents. Resident #18, had an open foil package of Ipratropium Bromide 0.5 mg and albuterol sulfate 3 mg vials were observed open with no open date on it. Also, 20 packets of white petrolatum skin protectant containers were observed with an expiration date of 10/2013.</p> <p>During an observation on 02/19/14 at 10:46 A.M., of the blue hallway medication cart with LPN #16, Resident #80 had an opened Ipratropium bromide 0.5 mg and albuterol sulfate 3 mg were observed open and labeled on foil package: discard after 1 week date, and was opened 01/24/14.</p> <p>During an interview on 2/19/14 at 10:52 A.M., LPN #16 indicated</p>		<p>open date documented on them but are not dated, have been replaced by the facility. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> On 3-10-14, all medication carts on all units have been audited by the pharmacist and any expired medications have been removed and destroyed per facility policy. All open medications in all carts requiring "Date Opened" documented on them have been audited and replaced if unmarked. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>1. Nursing Staff to be inserviced on "Medication Expiration List" effective 3-20-14.</p> <p>2. Unit managers to audit all of their medication and treatment carts on their respective units twice weekly x4 weeks, weekly x4 weeks, then monthly to ensure everything is labeled and expired medications destroyed appropriately.</p> <p>3. Pharmacist to audit all medication and treatment carts monthly x 3months, then every other month to ensure everything is labeled and expired medications destroyed appropriately.</p> <p>4. Wound nurse to audit treatment cart weekly x4 then monthly to ensure all treatments are labeled appropriately and expired items are removed and</p>		

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	<p>whoever opened a medication should write an open date on the medication. She further indicated everyone should be checking for expired medications prior to administrating them.</p> <p>During an observation on 2/19/14 at 11:04 A.M. of the Blue hallway medication cart #2, Resident #44 had an opened foil package of Ipratropium bromide 0.5 mg and albuterol sulfate 3 mg were observed open with no open date. Resident # 97 had an opened Nitrostat sub (sublingual) 0.4 mg bottle observed with no open date. Also, 1 packet of Povidone-Iodine swabstick container were observed with expiration date of 11/2012, and 1 packet of white petroleum skin protectant containers were observed with an expiration date of 10/2013.</p> <p>During an interview on 02/17/14 at 2:43 P.M., RN #17 indicated expired medications, if unopened, are logged on sheet and put into medication room behind nurse's station and placed in a tote to be returned to pharmacy. If medications were opened, they were placed into a cup and then deposed off in a biohazard box. Then the box went into a biohazard bag, by employee</p>		<p>destroyed. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Wound Nurse's audits will be reviewed weekly with the Director of Nursing/Director of Quality Management. Results of the pharmacist's audits will be reviewed monthly with the Director of Nursing/Director of Quality Management. Results of the Unit Manager audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management. The Wound Nurse's audits, the pharmacist's audits and the Unit Manager's will be reviewed quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>		

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	<p>#100's office in locked room . 3-11 Nurse's took care of expired mediations. If it is equipment, was logged on a log sheet and given to Employee #100. Employee #100 was the supply person that ordered the equipment.</p> <p>On 02/19/14 at 11:23 A.M., the Director of Nursing provided a policy and procedure for expiration dates of medications and indicated this document is current. Titled: "EXPIRATION DATES of MEDICATIONS: ORAL MEDICATIONS: PRODUCT and EXP(EXPIRATION) DATE:Nitroglycerin products-6 months after opening....Tablets/capsules/bulk liquids in original package-Mfg (Manufactory) expiration date....Neb solutions(DuoNeb, Pulmicort)(entire package in wrapper-7 days after opening foil package...."</p> <p>3.1-25(o)</p>			

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F000441 SS=F	<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> <p>Based on observation, interview and record review the facility failed</p>	F000441	<u>What corrective action will be done by the facility?</u> Hubbard Hill	03/25/2014	

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	<p>maintain infection control procedures related to handwashing and covering linen carts. This had the potential to effect all residents in the facility. The facility also failed to ensure the covering a CPAP (continuous positive airway pressure) mask for 1 of 1 resident reviewed. (Resident #57)</p> <p>Findings include:</p> <p>1. On 02/20/14 at 10:28 A.M., Unit Manager #10 was observed washing her hand for 10 seconds, before she donned gloves. She then undressed and repositioned the Resident #57 to expose his wound, and opened dressing change supplies for LPN #13.</p> <p>The Infection Control Manual for this facility was provided by the Director of Quality Management on 02/20/14 at 3:00 P.M. This current policy indicated the following: "PURPOSE: To decrease the risk of transmission of infection by appropriate hand hygiene. POLICY: Handwashing/hand hygiene...I. HANDWASHING When hands are visibly...A. Turn on water to a comfortable warm temperature. B. Moisten hands with soap and water and make a heavy lather. C. Wash</p>		<p>policy states that linens are transported in carts used exclusively for this purpose. Policy will be reviewed with nursing staff and laundry staff effective 3-20-14. Handwashing policy will be reviewed with nursing and activity staff effective 3-20-14. CPAP mask stored in bag when not in use. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Allareas with linen carts will be audited to assure coverage of linens effective 3-20-14. Residents with CPAP machines have their masks in bags when not in use. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>1.Nursing Staff, laundry staff and Activity staff will be inserviced by March 20, 2014 on Infection Control related to Proper Handwashing Technique.</p> <p>2.Unit managers to audit shower rooms and linen transport on their respective halls daily on days of work to assure linens are covered.</p> <p>3.Housekeeping/Laundry manager or designee to audit shower rooms and linen transport daily on days of work to assure linens are covered.</p> <p>4.Nursing staff and Laundry staff will be inserviced by March 20, 2014 on proper handling and storage of linens.</p> <p>5.Nursing staff will be</p>		

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	<p>well under running water for a minimum of 20 seconds, using a rotary motion and friction...."</p> <p>2. On 02/20/14 at 10:39 A.M., during Resident #57's wound care the resident's CPAP (Continuous Positive Airway Pressure) mask was observed sitting on top of the machine uncovered.</p> <p>During an observation on 02/20/14 2:42 P.M., Resident #57 was observed sitting in her w/c (wheelchair), on gel cushion, in room talking with a visitor with the resident's CPAP mask was sitting on top of the machine uncovered.</p> <p>During an observation on 02/21/14 at 9:29 A.M., Resident #57 was observed sitting in her wheelchair, eyes closed. The resident's CPAP mask sitting on top on the machine uncovered.</p> <p>During an interview on 02/21/14 at 9:35 A.M., CNA #19, indicated that the resident's CPAP mask should be covered.</p> <p>During an interview on 02/21/14 at 9:37 A.M., CNA #18, indicated that the resident's CPAP mask should be covered.</p>		<p>inserviced by March 20, 2014 on proper storage of the CPAP mask.</p> <p>1. Nursing Unit Managers to observe 5 staff members through random observations and audits three times per week x4 weeks, weekly x4 weeks, then monthly, on scheduled days of work to ensure proper handwashing.</p> <p>2. Activity Director or designee to observe 5 staff members through random observations and audits three times per week x4 weeks, weekly x4 weeks, then monthly, on scheduled days of work to ensure proper handwashing. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Unit Manager audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/Director of Quality Management. Activity Director/designee audits will be reviewed bi-weekly in Activity meeting with Administrator. Both will be reviewed quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>				

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	<p>During an interview on 02/21/14 at 9:39 A.M., LPN #13, indicated that the resident's CPAP mask should be in a bag.</p> <p>3. On 2/17/14 at 12:24 P.M., CNA #2 was observed in the health care dinning room washing his hands 14 seconds then returning to feed Resident #55.</p> <p>On 2/19/14 at 11:49 A.M., RN #7 was observed in the health care dinning room washing her hands for 15 seconds.</p> <p>On 2/19/14 at 11:49 A.M., Activities #3 was observed in the health care dinning room washing her hands for 15 seconds. She turned off water with her bare hands then dried them with paper towels.</p> <p>On 2/19/14 at 11:49 A.M., CNA #4 was observed in the health care dinning room washing her hands for 12 seconds then she began feeding Resident #55.</p> <p>During an interview on 2/21/14 at 11:00 A.M., CNA #2 indicated, handwashing should be for at least 20 seconds, then dry hands with paper towels, turn off the water with</p>			

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	<p>a clean paper towel.</p> <p>During an interview on 2/21/14 at 1:46 P.M., Activities #3 indicated, staff were to wet hands, apply soap, wash hands for twenty seconds, washing under the nails up to wrists, turning water off with paper towels. Staff were to wash hands in between resident contact.</p> <p>On 2/20/14 at 1:15 P.M., a review of policy titled "Handwashing," dated 9/2008, indicated ... 1. Wet your hands with running water as hot as you can comfortably stand...2. Apply soap. 3. Vigorously scrub hands and arms 10-15 seconds... 4. Rinse thoroughly under running water. 5. Dry hands and arms with paper towel. Use the paper towel to turn off the faucet... The whole process should take approximately 20 seconds....</p> <p>4. On 2/17/14 at 10:05 A.M., an uncovered clean linen cart was observed in the red hall shower room. In addition, a soiled linen cart with the lid ajar was observed in the red hallway, which exposed the dirty linen.</p> <p>On 2/20/14 at 12:50 P.M., an</p>			

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	<p>uncovered resident linen cart containing resident's personal clothing was observed in the hall outside room 2401 with no staff around.</p> <p>On 2/20/14 at 12:51 P.M., a linen cart which contained resident's personal clothing was observed uncovered. The cart was being pushed between rooms in the red hallway by laundry staff #6.</p> <p>During a interview, on 2/20/14 at 1:03 P.M., laundry staff # 6 indicated, clean linen cart can be open when going from room to room but covered when going from hall to hall. Dirty linens are collected in soiled utility room and then transported with lids closed to laundry.</p> <p>On 2/20/14 at 3:10 P.M., CNA #5 was observed pushing a linen cart with gowns on top of cart, uncovered to room 2103. CNA #5 took a towel, wash cloth and gown off cart and took into in room 2103. CNA #5 was then observed pushing linen cart to room 2105 taking a towel, wash cloth and gown off cart and taking it into room 2105.</p> <p>During a interview, on 2/20/14 at</p>				

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	<p>3:18 P.M., CNA #5 indicated, linens should be transported with the linen cart covered and linens should not be on top.</p> <p>During a interview, on 2/21/14 at 10:10 A.M., Dietary Manager #32 indicated, Linen carts transporting residents clean laundry should be kept closed at all times, not to be open when going in between resident rooms or down hallway. Each individual hall has there own resident clean laundry cart. Linen carts in shower rooms should be kept covered at all times.</p> <p>On 2/20/14 at 3:30 P.M., review of undated policy titled "Transportation of Linen," indicated no specific policy and procedure describing the exact manner of how linens should be transported or stored on clean linen carts was indicated.</p> <p>3.1-18(l) 3.1-19(g)(1)(2)(3)</p>				