

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2012
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00103864.</p> <p>Survey dates: February 13, 14, 15, 16, 17, 19, & 20, 2012.</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Janet Adams, RN, TC February 14, 15, 16, 17, & 20, 2012 Lara Richards, RN February 13, 14, 15, 16, 17, & 20, 2012 Heather Tuttle, RN February 13, 14, 15, 16, 17, & 20, 2012 Kathleen Vargas, RN</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payor type: Medicare: 21 Medicaid: 37 Other: 13 Total: 71</p>	F0000	<p>The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Stage 2 Sample: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/24/12 Cathy Emswiller RN</p>			
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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the residents' physician and/or family member were notified in a timely manner following a condition change related to a medication</p>	F0157	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the	03/21/2012			

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	<p>allergy, increased lethargy as well as weight loss and decreased appetite for 1 of 3 residents of the 9 who met the criteria for non-pressure skin conditions, for 1 of 3 residents of the 7 who met the criteria for hospitalization within the first 30 days of admission and for 1 of 3 of the 6 residents who met the criteria for nutrition. (Residents #C, #D, and #F)</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 2/15/12 at 8:45 a.m. and on 2/17/12 at 8:35 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and deep vein thrombosis (blood clot).</p> <p>A Physician's order dated 2/16/12, indicated the resident was to receive Augmentin (an antibiotic) 875 mg (milligrams) twice a day for 3 days due to cellulitis of the right hand.</p> <p>Documentation in the Nursing Progress Notes on 2/16/12 at 5:15 p.m., indicated the pharmacy called and stated the resident was allergic to the prescribed antibiotic. The Physician was notified and staff were waiting for a call back. At 7:00 p.m., staff attempted to call the Physician back. A voice message was left with no</p>		<p>resident found to have been affected by the deficient practice was resident F medical record was reviewed for current allergies and Dr. was notified of res. allergy to Augmentin on 2/17/12 by ADON during the survey. Res. C returned to the facility on 1/29/12 and was reassessed by the DON on 2/21/12 with noted improvement. Resident D was reweighed by CNA on 2/15/12 during the survey and her weight was stable at present. The corrective action for those residents having the potential to be affected by the same deficient practice is DON has audited medical records on 3/2/12 to identify any omitted allergies. ADDENDUM: All residents were audited to determine if there was a decrease in food consumption or change of condition by the ADON to ensure physician/family has been notified in a timely manner. All residents were reweighed during the survey. Residents with a 5 lb wt loss/gain will be reweighed with in 24 hrs and family and physician will be notified by staff nurse. Care plans will be updated to reflect current status. Communication slips will be sent to appropriate departments for interventions. The measures put into place and a systemic change made to endure the deficient practice</p>				

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	<p>return call. Documentation at that time, indicated staff would speak with the physician tomorrow. There was no documentation of any attempts to call an alternate Physician or the Medical Director in the above entries.</p> <p>Documentation in the Nursing Progress Notes on 2/17/12 at 12:30 p.m., indicated the resident was seen by the Physician and an order was obtained for a new antibiotic.</p> <p>Interview with LPN #2 on 2/20/12 at 1:55 p.m., indicated if the resident's primary physician did not respond after a few attempts, then the Medical Director should be called.</p> <p>2. The record for Resident #C was reviewed on 2/15/12 at 1:17 p.m. The resident's diagnoses included, but were not limited to, infected decubitus ulcer, hyperactivity, and anxiety.</p> <p>An entry in the Nursing Progress Notes dated 1/22/12 at 9:55 p.m., indicated the resident was found on the floor on his back. The Physician was notified at this time and orders were received.</p> <p>Documentation in the Nursing Progress Notes dated 1/23/12 at 12:00 a.m., indicated the resident was lethargic at</p>		<p>does not reoccur nursing staff have been re-educated relative to appropriate interventions regarding allergies, falls, change of condition and weight loss on 3/2-3/9 by the DON/SDC. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit phone orders, 24 hour report for allergies, falls and any wt loss Monday - Friday to ensure physician/family have been notified timely. Addendum: The Director of Clinical Services/designee will audit 30% of the food consumption records 2 X weekly to verify compliance. DON/designee will monitor results weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution. .</p>				

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	<p>first. Difficult to arouse. When he became more responsive he was confused, inappropriate, unable to follow commands, in answer to questions repeated "Catholic Charities" over and over. Able to move arms, hand grasps weak bilateral. The resident's blood pressure was 100/67 and his pulse was 101.</p> <p>At 2:30 a.m., documentation indicated there was no change in the resident's neurological assessment, he remained confused and was talking to himself. He was orientated to name only.</p> <p>Documentation at 4:15 a.m., indicated the resident remained lethargic. He was speaking in a whisper, and remained confused. At 4:30 a.m., the Physician was notified of the resident's status and orders were received. The resident was admitted to the hospital with the diagnoses of urinary tract infection (UTI), multiple falls, and sepsis secondary to UTI and multiple decubitus.</p> <p>Interview with LPN #1 on 2/20/12 at 1:20 p.m., indicated the physician should have been notified in a more timely manner related to the resident's lethargy on 1/23/12.</p>			

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	<p>3. The record for Resident #D was reviewed on 2/13/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, senile dementia, high blood pressure, convulsions, depressive disorder, and osteoarthritis.</p> <p>The 2011 and 2012 Weight Records indicated the following weights were recorded: 09/10/11 207.10 pounds 10/10/11 203 pounds 11/08.11 204.10 pounds 12/09/11 203 pounds 01/10/12 201.9 pounds 02/07/12 184 pounds 02/15/12 185 pounds</p> <p>The January 2012 Monthly Flow record for food consumption indicated the resident's intakes were as follows: 1/22/12 Breakfast: 0% Lunch: 50% Dinner: not recorded</p> <p>1/23/12 Breakfast: 0% Lunch: 25% Dinner: less then 25% HS snack: 0%</p> <p>1/24/12</p>	F0157	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was resident F medical record was reviewed for current allergies and Dr. was notified of res. allergy to Augmentin on 2/17/12 by ADON during the survey. Res. C returned to the facility on 1/29/12 and was reassessed by the DON on 2/21/12 with noted improvement. Resident D was reweighed by CNA on 2/15/12 during the survey and her weight was stable at present. The corrective action for those residents having the potential to be affected by the same deficient practice is DON has audited medical records on 3/2/12 to identify any omitted allergies. ADDENDUM: All residents were audited to determine if there was a decrease in food consumption or change of condition by the ADON to ensure physician/family has been notified in a timely manner. All residents were reweighed during the survey. Residents with a 5 lb wt loss/gain will be reweighed with in 24 hrs and family and physician will be notified by staff nurse. Care plans will be updated to reflect</p>	03/21/2012			

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	<p>Breakfast: 0%</p> <p>Lunch: 75%</p> <p>Dinner: 0%</p> <p>HS snack: 0%</p> <p>1/25/12</p> <p>Breakfast: 25%</p> <p>Lunch: 25%</p> <p>Dinner: less then 25%</p> <p>HS snack: 25%</p> <p>1/26/12</p> <p>Breakfast: 0%</p> <p>Lunch: 0%</p> <p>Dinner: less then 25%</p> <p>HS snack: less then 25%</p> <p>1/27/12</p> <p>Breakfast: 0%</p> <p>Lunch: 0%</p> <p>Dinner: less then 25%</p> <p>A Nutritional Progress noted dated 2/17/12 indicated the resident had a significant weight loss of 8% in the past 30 days.</p> <p>The resident's current care plans were reviewed. There was no care related to the resident being on any planned weight loss program during the above months.</p> <p>There was no documentation in the</p>		<p>current status. Communication slips will be sent to appropriate departments for interventions. The measures put into place and a systemic change made to endure the deficient practice does not reoccur nursing staff have been re-educated relative to appropriate interventions regarding allergies, falls, change of condition and weight loss on 3/2-3/9 by the DON/SDC. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit phone orders, 24 hour report for allergies, falls and any wt loss Monday - Friday to ensure physician/family have been notified timely. Addendum: The Director of Clinical Services/designee will audit 30% of the food consumption records 2 X weekly to verify compliance. DON/designee will monitor results weekly for the first month, monthly for the first quarter and quarterly there after for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution. .</p>				

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	<p>2/2012 Nurses' Notes related to the resident's family/responsible party receiving notification of the recent weight loss.</p> <p>The 1/2012 Nurses' Notes were reviewed. There was no documentation the physician was notified of the residents decreased food consumption 1/22/12 thru 1/27/12. An entry made on 1/27/12 at 2:30 p.m. indicated the resident's daughter voiced concerns related to the resident's lethargy. The entry also indicated the resident was moving around very little and not drinking. The next entry was made on 1/27/12 at 8:00 p.m. This entry indicated the resident was being transferred to the hospital for evaluation and treatment.</p> <p>The 1/27/12 hospital Emergency Department notes indicated the resident had decreased oral intake and infection. The note also indicated the resident was asking for something to drink. The note also indicated the Nursing Home staff indicated the resident did not eat or drink water for two days.</p> <p>The facility policy titled "Changes in Resident's Condition or Status" was received from the Director of Nursing on 2/16/12 at 11:30 a.m. There was no date on the policy. The Director of Nursing</p>			

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	<p>indicated the policy was current. The policy indicated the resident, attending Physician, and residents' representative were to be notified of changes in the resident's condition and/or status. The policy indicated Nursing was responsible to notify the attending Physician and the resident and the residents' representative of any significant change in the resident's physical, mental, or emotional status. The policy also indicated the Nursing staff were to notify the Physician of any need to alter the residents treatment or medications significantly. All notifications were to be made as soon as practical and not exceeding twenty-four hours.</p> <p>When interviewed on 2/20/12 at 10:30 a.m., the Director of Nursing indicated the resident's family should have been notified of the weight loss.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>						

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on observation, record review and interview, the facility failed to resolve grievances in a timely manner related to missing glasses for 1 resident of the 1 who met the criteria for personal property. (Resident #F)</p> <p>Findings include:</p> <p>On 2/14/12 at 3:10 p.m., Resident #F was observed being transferred into his wheelchair. The resident was not wearing glasses.</p> <p>On 2/15/12 at 8:30 a.m., the resident was observed sitting a wheelchair in his room. The resident was not wearing glasses.</p> <p>On 2/17/12 at 8:29 a.m., the resident was observed sitting in a wheelchair in the Dining Room. The resident was not wearing glasses.</p> <p>Interview with Resident #F's wife on 2/13/12 at 12:40 p.m., indicated the resident's glasses had been missing for a couple of months and the resident still did not have his glasses</p>	F0166	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: The glasses for resident F have been ordered and paid for and family has been notified. The resident on 3/7/2012 received the glasses. The corrective action taken for those residents having the potential to be affected by the same deficient practice is an audit was completed of the concern log and there were no other residents with grievances that had not been followed up on timely. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur is all departments have been in-serviced on 2/24 – 3/9/12 on the timely use of the concern form and on the grievance procedure and follow up when a resident or family member has a concern. To ensure the deficient practice does not reoccur, the monitoring system established is the concern log will be reviewed weekly by the Executive</p>	03/21/2012			

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	<p>The record for Resident #F was reviewed on 2/15/12 at 8:45 a.m. and on 2/17/12 at 8:35 a.m.</p> <p>The 12/12/11 and 1/17/12 Care Plan Conference Records, indicated the resident had missing glasses.</p> <p>A Concern/Grievance form was provided by the Social Service Director on 2/17/12. The date on the form indicated the Grievance was filed on "12/12/12" [sic] (incorrect year written) by the resident's wife related to the resident missing his eyeglasses.</p> <p>The Section titled "Steps taken to resolve concern", indicated the resident was to be seen by the [name of company] eye doctor at the next visit. The resident's wife provided Social Service with the telephone number of his own Optometrist to fax over his prescription. Offered reading glasses. Prescription fax from optometrist's office. Prime Source in on 2/14/12. Wife notified. This section was signed and dated by the Social Service Director on "12/2/12".</p> <p>A list provided by the Social Service Director on 2/20/12, indicated the [name of company] Optometrist was in the facility on 2/14/12. There were no notes</p>		<p>Director/designee to verify that all concerns have been followed up with timely. The Executive Director or designee will complete weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>				

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	<p>from the optometrist in the resident's record.</p> <p>Interview with the Director of Nursing on 2/20/12 at 11:30 a.m., indicated the resident was seen by [name of company] on 2/14/12, for frames only. She indicated the facility received a statement from [name of company] on 2/15/12 for being seen on 2/14/12 for \$205. She indicated the facility would pay the bill for the glasses since they were lost at the facility. Continued interview at the time, indicated she could not explain the conflicting dates on the Complaint/Grievance form and that the issue with the glasses should have been acted upon in a more timely manner since the issue was first brought up in December 2011.</p> <p>The facility policy titled "Concern and Comment Program" was reviewed on 2/20/12 at 10:15 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated the persons completing the form will take adequate time to record the concern comprehensively or allow the concerned individual to record their comments. Complete information will help to facilitate a comprehensive and prompt follow-up. If possible, the concern will be resolved by the person accepting the information. When unable to resolve the</p>				

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	<p>concern, share with the individual that someone who will be assigned to investigate the concern will get back with them as soon as possible. If the concern is of major importance, the staff should contact the administrator, director of nursing, or designee as soon as possible. The Concern and Comment Form is then routed to the administrator or designee and to the appropriate department manager who will investigate and resolve the concern.</p> <p>3.1-7(a)(1)</p>						

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F0223 SS=A	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from abuse related to a substantiated allegation of abuse for 2 of 4 residents reviewed for abuse allegations in the Stage Two Sample of 35. (Resident #B and #123)</p> <p>Findings include:</p> <p>Review of State Reportables(unusual incidents or occurrences that required to be reported) on 2/20/12 of an allegation of abuse indicated during the midnight shift on 2/17/12 in the early a.m., Resident #123 had indicated a CNA had entered her room and threw Resident #B's call light on the floor, left the room and shut the door.</p> <p>Review of the incident report form indicated on 2/17/12 at 11:00 a.m., that a friend of Resident #123 came into and reported to Administrator that early in the morning on the midnight shift on 2/17/12,</p>	F0223	<p>It is the practice e of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:The corrective action taken for the resident found to have been affected by the deficient practice was: The facility followed all policies and procedures for abuse. Resident #123 and her friend reported the incident that happened to her room mate Resident #B. Residents # B was addressed immediately upon being made aware of the situation of a call light being removed from reach and the CNA with unusual facial markings was taken off the schedule until the investigation was completed. The alleged incident was reported to state agencies as required in the approved time frame. Upon completion of our investigation the Executive Director terminated the CNA.The corrective action for those residents having the potential to be affected by the same deficient practice is all in house residents have the</p>	03/21/2012	

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	<p>an aide with unusual facial markings answered the call light in their room and took the call light threw it on the floor and shut the door. The friend indicated it was the girl with the unusual facial marking.</p> <p>Review of witness statements and interviews dated 2/17/12 at 11:46 a.m., indicated the Administrator went down to the resident's room to speak with Resident #123. The Administrator had taken a CNA who spoke fluent Spanish to interrupt if needed. Resident #123 indicated her roommate Resident #B was screaming "help me." When the aide came in, she just threw the light behind the curtain and never helped Resident #B at all. The CNA left the lights out and the television on and walked out of the room. Resident #123 then got up and walked out into the hallway and sat in a chair outside of her room because Resident #B kept on crying and that had bothered her.</p> <p>The Director of Nursing then spoke with another CNA who had worked that midnight shift. She indicated she had heard someone talking loud and complaining about the resident in (room number).</p> <p>Continued review of the witness statements indicated the Unit Coordinator</p>		<p>potential to be affected. An audit of Guardian Angel Calls from 30 days prior to date of exit has been completed to ensure that the facility policy and procedures has been followed. There were no other issues identified through this audit. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur The facility will continue to follow abuse and neglect policies for facility residents. Staff have been re-inserviced on abuse and neglect by Administration on 2/24 – 3/9/12 and will continue to be educated during orientation and quarterly on abuse and neglect. Department Heads will continue with their monthly Guardian Angel Calls and questioning residents and or family members about any allegations of abuse. To ensure the deficient practice does not reoccur, the monitoring system established is 50% of our interviewable residents or families will be interviewed by administration monthly with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>		

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	<p>who works the 3-11 shift interviewed the midnight nurse who was working that morning of 2/17/12. The midnight nurse indicated that when she entered the Resident #123's and #B's room, Resident #B's call light was on the floor, so she picked it up and gave it to the resident.</p> <p>Interview with the Administrator on 2/20/12 at 2:44 p.m., indicated the entire investigation was not yet completed due to what other statements Resident #B had made during the interviews, however, she did indicate the allegation of the CNA throwing the Resident B's call light on the floor and walking out of the room and shutting the door without helping her was substantiated and the CNA was terminated on Friday 2/17/12. The Administrator indicated she and the Director of Nursing had interviewed the residents and they were not having any problems from the incident. They were also interviewed by Social Services on 2/17/12 and both residents indicated they were not afraid here.</p> <p>3.1-27(b)</p>				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure medically-related social services were provided related to monitoring of behaviors and psychotropic medications for 2 of 3 residents of the 11 who met the criteria for anti-psychotic medications. (Residents #C and #119)</p> <p>Findings include:</p> <p>1. The record for Resident #C was reviewed on 2/15/12 at 1:17 p.m. The resident's diagnoses included, but were not limited to, anxiety and hyperactivity.</p> <p>A Physician's order dated 2/7/12, indicated the resident was to receive Valium (an anti-anxiety medication) 5 milligrams (mg) every 6 hours as needed for anxiety.</p> <p>Documentation in the Nursing Progress Notes on 1/7/12 at 1:30 p.m., indicated the resident was alert, nervous and had anxiety. Documentation also indicated the resident used the call light frequently. Documentation at 5:00 p.m., indicated the</p>	F0250	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was the Social Service progress note for resident C has been developed and addresses the residents' behavior and anti-anxiety use. Social Service has updated Res. 119 social service assessment. The corrective action taken for those residents having the potential to be affected by the same deficient practice is A facility wide audit of all residents medical records has been conducted to ensure the presence of current social service progress notes of each resident. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur is the Social Services Director has been in-serviced by the Social Services Consultant on 3/7/2012 relative to the timely and thorough documentation. To ensure the deficient practice does not reoccur, the monitoring system established is 30% of the active</p>	03/21/2012			

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	<p>resident remained nervous and was sometimes agitated.</p> <p>An entry in the Nursing Progress Notes on 1/11/12 at 8 p.m., indicated the resident refused all of his medications.</p> <p>Documentation in the Nursing Progress Notes on 1/12/12 at 11:30 a.m., indicated the resident was hallucinating and stated, "people have guns and are trying to shoot everyone."</p> <p>The plan of care dated 1/13/12, indicated the resident displayed repeated criticism of nursing home staff. The following interventions were listed:</p> <ul style="list-style-type: none"> -Visit with me on a routine basis, establishing a trusting relationship. -Guide conversation to prevent entire session from becoming a "gripe session." -Try to get me to determine if my expectations are realistic or not. -Do not criticize or talk down to me. -Involve me in all decisions regarding my care. -Praise me for all attempts to resolve conflicts. <p>There were no Social Service Progress Notes in the resident's record.</p> <p>Interview with the Social Service Director</p>		<p>medical records will be audited by the Medical Record Director or designee to evaluate compliance with the timely and thorough social services documentation. The Medical Record Director or designee will complete monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>		

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	<p>on 2/16/12 at 3:45 p.m., indicated that she thought she had completed notes on the resident. After looking through folders and binders, she could not find anything for the resident. The Social Service Director then indicated that she didn't have anything for the resident and she would have to complete some notes related to the resident's behavior and prn (as needed) anti-anxiety medication.</p> <p>2. The record for Resident #119 was reviewed on 2/16/12. The resident was admitted to the facility on 1/27/12 from the hospital. The resident's diagnoses included, but were not limited to, lung cancer with brain metastasis, COPD (chronic obstructive pulmonary disease), hepatitis C, depression, and anxiety.</p> <p>Review of the initial Minimum Data Set (MDS) full assessment dated 2/2/12 indicated the resident had received antipsychotic and antidepressant medications in the last seven days.</p> <p>Review of Physician Orders dated 1/27/12 indicated the resident was receiving Celexa (an antidepressant medication) 40 milligrams (mg) one tablet for depression and Seroquel (an antipsychotic</p>						

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	<p>medication) 300 mg one tab at night time.</p> <p>Review of the history and physical from the hospital admission dated 1/9/12 indicated the resident had history of bipolar disorder and was currently receiving Seroquel.</p> <p>Review of initial social history dated 2/3/12 completed by Social Service Director indicated under medical and psychiatric history indicated "has ca (cancer) with mets." There was no evidence of any documentation of the resident receiving the Seroquel or of his past psychotic problems.</p> <p>Review of the Social service notes dated 1/30/12 indicated the resident was alert with confusion and the resident has cancer with brain metastasis. She further indicated the resident was to be a short term stay.</p> <p>The next documented entry in Social Service Progress Notes was on 2/1/12 and there was no evidence of the resident receiving the antipsychotic or antidepressant medications. There was also no evidence of any documentation addressing the resident's concerns about his health conditions related to his cancer.</p> <p>The last documented entry in Social</p>				

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	<p>Service Progress Notes was on 2/15/12 which indicated the resident's girlfriend came in with her puppy, and the resident was happy.</p> <p>Review of the PASRR (preadmission screening resident review) level two assessment dated 1/19/12, indicated the resident had the diagnoses of bipolar disorder and depression, which indicated the individual was mentally ill.</p> <p>Interview with the Social Service Director on 2/16/12 at 11:13 a.m., indicated she had not completed the resident's social service assessment as of today 2/16/12. She further indicated the Social Service Assessment was due on 2/2/12 and should have been completed at that time. She indicated the Social Service Assessment would have addressed the resident's mood and feelings regarding his current medical condition and she would have addressed his psychotropic medication at that time. The Social Service Director indicated she had not addressed the resident's medications of Celexa or Seroquel in her documentation or charting, nor had she addressed the resident's current medical condition.</p> <p>3.1-34(a)</p>						

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F0278 SS=E	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment was coded accurately related to dental status, range of motion, hospice, and documentation of height for 1 of 1 residents of the 1 who met the criteria for dental status, for 2 of 3 residents of the 13 who met the criteria for range of motion,</p>	F0278	<p>It is the practice e of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice the issues will be corrected on the next scheduled MDS for Res. 60, Res. K , Res. F, Res. 77 and Res.</p>	03/21/2012			

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	<p>for 1 of 1 residents reviewed for hospice services and for 1 of 3 residents of the 6 who met the criteria for nutrition. (Residents #F, #K, #60, #77 and #95)</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 2/15/12 at 8:45 a.m. and on 2/17/12 at 8:35 a.m. The resident's diagnoses included, but was not limited to, Parkinson's disease.</p> <p>The Quarterly MDS Assessment dated 1/27/12, indicated the resident had impairment in functional range of motion on both sides of his upper and lower extremities.</p> <p>Interview with Physical Therapy Staff Member #1 on 2/20/12 at 1:40 p.m., indicated a limitation in range of motion was noted in the resident's upper extremities but not the lower extremities.</p> <p>Interview with the MDS Coordinator on 2/20/12 at 2:30 p.m., indicated that she reviews the therapy notes to determine the resident's range of motion status. The MDS Coordinator indicated the 1/27/12 MDS was coded wrong related to lower extremity range of motion. She indicated the resident had no range of motion impairment of the lower extremities.</p>		<p>95. The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>Addendum: An audit of 25% of the MDSs that were completed during the last 30 days was completed to ensure compliance. Any concerns were brought to the attention of the MDSs coordinator for timely correction. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur is: Staff members responsible for completing the MDSs have been in-serviced on steps needed to be taken to assure accuracy on 3/1/2012 by Senior Director of Nursing Linda Filan RN. To ensure the deficient practice does not reoccur, the monitoring system established is 30% of OBRA assessments will be audited prior to transmission by the Executive Director or designee to evaluate compliance with assessment accuracy prior to being transmitted. The Executive Director or designee will complete monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>				

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	<p>2. The record for Resident #60 was reviewed on 2/15/12 at 10:57 a.m.</p> <p>Review of the initial MDS assessment dated 1/23/12 indicated the resident was coded as having no limitations to range of motion for her upper extremities.</p> <p>Review of the Medicare MDS assessment dated 1/30/12 indicated the resident was coded as having a decline in functional status for range of motion for the upper extremities on both sides.</p> <p>Review of the Occupational Therapy 1/17/12 and 1/30/12 assessments indicated the resident demonstrates decreased bue (bilateral upper extremity) strength, functional endurance, standing/balance/tolerance and decreased safety and independence for self care and transfers. The strength of the resident demonstrates bilateral upper extremity 4/5 good (full range of motion against gravity and moderate resistance) with exception of right proximal muscle strength at 2</p>						

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	<p>plus/5.</p> <p>Interview with Occupational Therapist #1 on 2/14/12 at 2:50 p.m., indicated the resident has a limited range of motion to her right proximal shoulder area. She further indicated the resident's functional mobility to her shoulder had not changed and was only limited to the right side. She indicated the resident was admitted to the facility with this limitation and had not had a decline in range of motion. The Occupational Therapist indicated the coding for the initial MDS was inaccurate.</p> <p>Interview with MDS Coordinator on 2/14/12 at 3:03 p.m., indicated she had coded the resident as not having a limited range of motion on the initial assessment based on the therapy's documentation. She further indicated at that time, she did not fully understand their coding and the MDS was inaccurately coded.</p> <p>3. The record for Resident #95 was reviewed on 2/15/12 at 8:44 a.m. The resident's diagnoses included,, but were not limited to, traumatic brain injury, coronary artery disease, permanent pacemaker, dementing illness associated</p>						

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	<p>with behaviors, and depression.</p> <p>The 2/2012 Physician Order Statement was reviewed. There was a Physician's order for the resident to receive Hospice services. The order was originally obtained on 9/2/11. The 12/2/11 Minimum Data Set (MDS) quarterly assessment indicated the section related to the resident's prognosis was not marked to indicate the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months.</p> <p>When interviewed on 2/17/12 at 11:42 a.m., the MDS Coordinator indicated the resident was on Hospice and the section related to the prognosis was not coded correctly.</p> <p>4. The record for Resident #77 was reviewed on 2/15/12 at 1:02 p.m.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 1/10/12, was reviewed. The MDS indicated the resident's height was 63 inches.</p> <p>The form titled, "Initial Data Collection Tool" dated 1/3/12, indicated the resident's height was 5 foot 1 inch.</p> <p>The form titled, "Nutrition Data</p>				

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	<p>Collection/Assessment" dated 1/5/12, indicated the resident was 60 inches tall.</p> <p>Interview with the MDS Coordinator on 2/15/12 at 2:03 p.m., indicated the MDS was not accurately coded related to the resident's height.</p> <p>5. Resident #K was observed on 2/15/12 at 8:48 a.m. in bed. The resident was eating breakfast, she was observed to have several missing teeth and some teeth in poor condition.</p> <p>The record for Resident #K was reviewed on 2/15/12 at 9:04 a.m.</p> <p>The resident was seen by the Dentist on 3/10/10. The dental report, signed by the Dentist on 3/10/10, indicated the resident had two fractured teeth (#8 and #9) and two root tips (#7 and #10). The report indicated the resident had no other teeth.</p> <p>The Annual MDS full assessment dated 7/29/11, indicated the resident had no dental problems. The MDS did not indicate that the resident had broken natural teeth.</p> <p>Interview with the MDS Coordinator on 2/15/12 at 10:45 a.m., indicated the MDS was inaccurately coded. She indicated the residents broken teeth should have been</p>						

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	coded on the MDS. 3.1-31(d)				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews, the facility failed to ensure a comprehensive plan of care was completed for 1 of 3 residents reviewed for psychoactive medication of the 9 who met the criteria for psychoactive medications, for 1 of 3 residents reviewed for range of motion of the 14 who met the criteria for range of motion, and for 1 of 3 residents reviewed for urinary tract infections. (Residents #88, #H, and #119)</p> <p>Findings include:</p>	F0279	It is the practice e of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: Resident 119 care plan was reviewed and updated on 2/16/12 by Clinical Compliance Coordinator during the survey. Resident H Care Plan was reviewed and updated on 2/21/12 by the ADON during survey. Resident 88 discharged home on 12/31/11. The corrective action taken for those	03/21/2012	

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	<p>1. The record for Resident #119 was reviewed 2/16/12 at 8:36 a.m.</p> <p>Review of the initial Minimum Data Set (MDS) assessment dated 2/2/12 indicated the resident had received in the last seven day the medications of an antipsychotic and antidepressant medication.</p> <p>Review of the Care Area Assessment dated 2/7/12 indicated the care plan was completed and was signed by the care plan coordinator on 2/7/12.</p> <p>Review of the 2/7/12 current care plans indicated there was no care plan completed for psychotropic medication use.</p> <p>Interview with MDS Coordinator on 2/16/12 at 12:12 p.m., indicated that she was responsible for making the care plan for psychotropic medication.</p> <p>2. The record for Resident #H was reviewed on 2/17/12 at 12:55 p.m.,</p> <p>Review of the quarterly MDS dated 12/27/11 indicated the resident required extensive assist with a two person assist with bed mobility, transfer, locomotion on and off unit, dressing, eating, and personal hygiene.</p>		<p>residents having the potential to be affected by the same deficient practice is an outside consulting company will complete medical record audit on residents receiving psychoactive medications on 3/7/12 and care plans to be reviewed and updated accordingly. Medical records were reviewed for residents receiving restorative services by the Regional Director of Clinical services on March 2 and care plans will be updated to current status. Addendum: There were no other residents found not to have a care plan for a UTI. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur is Restorative nurse has been re-educated on redeveloping accurate care plans on specific programs with residents receiving restorative by the Restorative Service Manager. Care plan team was inserviced by senior DON Linda Filan RN on the care plan process on 3/1/2012</p> <p>Addendum: The Medical Records Director/designee will review care plans in the Change of Condition meeting which is held M-F and weekends are reviewed on Mon to assure care plans are in place or have been up dated as changes occur. To ensure the deficient practice does not reoccur, the monitoring system</p>				

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	<p>Review of Physician Orders dated 2/2/12 indicated Restorative therapy: AROM (active range of motion) to bilateral upper extremity hand bike times 15 minutes sit to stand 3 minutes times 5 sets, standing tolerances. PROM (passive range of motion) to bilateral upper extremities 20 reps times 2 sets.</p> <p>Further review of Physician Orders dated 1/30/12 indicated Restorative Therapy: BLE (bilateral lower extremity) leg bike times 20 minutes with 2 pound weights, bed to wheelchair transfers times 5 sets and ambulate 70 feet times 2 gait belt and CNA.</p> <p>Review of the current plan of care updated 12/27/11 indicated there was no care plan for Restorative Therapy services.</p> <p>Interview with the Assistant Director of Nursing on 2/20/12 at 12:17 p.m., indicated there was no care plan for restorative therapy for the resident.</p> <p>3. The closed record for Resident #88 was reviewed on 2/16/12 at 1:35 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, coronary artery disease, and diabetes mellitus. The resident was sent to</p>		<p>established is DON/designee will audit 30% of completed care plans weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education.</p>				

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	<p>the hospital on 12/5/11 from a dialysis center. The resident was returned to the facility on 12/13/11.</p> <p>The 12/13/11 Discharge Instructions indicated the resident was to receive Cipro (an antibiotic) 250 milligrams every 12 hours for one week. The 12/13/11 Physician orders indicated the resident was to receive Cipro 250 milligrams every 12 hours for one week for a diagnosis of a urinary tract infection.</p> <p>The resident's 12/13/11 thru 12/30/11 care plans were reviewed. There was no care plan in place related to the resident's urinary tract infection. The resident was discharged from the facility on 12/30/11.</p> <p>When interviewed on 2/16/12 at 4:06 p.m., the Medical Records employee indicated there was no care plan related to the resident's 12/13/11 urinary tract infection in the record. The Medical Records employee indicated she reviewed the resident's entire closed record and could not located a care plan related to and urinary tract infection.</p> <p>3.1-35(a)</p>				

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F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure physician's orders and/or the plan of care were followed as written related to the use of chair alarms, derma sleeves, elevating an extremity, nutritional supplements, treatments and medications not given as ordered, laboratory tests not done as ordered, the physician not notified of lab results as ordered, the use of non-skid foot wear, and documentation of shower refusals and food consumption for 1 of 3 residents of the 8 who met the criteria for accidents, for 2 of 3 residents of the 9 who met the criteria for non-pressure skin conditions, for 2 of 10 residents who were reviewed for unnecessary medications and for 1 resident of the 1 who met the criteria for activities of daily living. (Residents #B, #D, #F, #G, #H, #J, and #K)</p> <p>Findings include:</p> <p>1. On 2/16/12 at 8:35 a.m., Resident #F was observed in his room in bed. The resident was wearing a short sleeve shirt and he had no derma sleeve (a covering to</p>	F0282	<p>It is the practice e of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: Res #B is no longer in the facility. Res. #D had a follow up UA C&S with results 2/15 and 2/16. She received showers on 2/15 and 2/18/12, she was seen by the dietician on 2/16 and again on 3/1 with recommendation to add supplements to her POC. Resident F had Geri sleeves placed and arm was elevated by the CNA on 2/20/12. He had a clarification order written on 2/20 for use of a chair alarm and the Daily Care Guide reflects the order. Resident #G had non-skid socks applied. Resident H had restorative therapy initiated on 2/22/12 by the Restorative Nurse. Resident J received a dressing change by the wound care nurse on 2/17/12. Resident K had her dietary card audited to verify that it matches the PO. The Dietary Manager did verify that all items were received per tray card orders on 2/21/12. The corrective action taken for those residents</p>	03/21/2012			

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	<p>protect the skin) in place to the left arm. The resident's right arm was wrapped with a gauze dressing. At 9:20 a.m., the resident was seated in a wheelchair in his room. The resident's right hand was red and swollen. The resident's right arm was not elevated at this time. At 12:11 p.m., the resident's right hand remained edematous with redness. The 1/2 lap tray attached to the resident's wheelchair was not in use at this time, nor was the resident's right arm elevated.</p> <p>During observation on 2/17/12 at 8:29 a.m., the resident was seated in his wheelchair in the Restorative Dining Room. The resident's right arm was not elevated. The resident's right hand remained edematous and red in color.</p> <p>During observation on 2/20/12 at 8:30 a.m., 9:30 a.m., and 11:30 a.m., the resident was seated in a wheelchair in his room. The resident's right hand remained red with some edema. The resident's hand was not elevated at this time. Further, the resident did not have on derma sleeves to either arm. The resident's chair alarm was not attached at the above times either.</p> <p>The record for Resident #F was reviewed on 2/15/12 at 8:45 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, dementia and</p>		<p>having the potential to be affected by the same deficient practice is an audit was completed by the infection control nurse of physician orders over the last two weeks for UA's to verify they have been processed properly. The dietician to verify that the tray cards matched physician orders for supplements completed a house wide audit. The department heads to completed a house wide audit of the residents to verify that restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered were in proper place. Nursing management competed a house wide audit to verify that the care guides and care plans matched. A audit was completed by the Rehab Service Manager of the last 30 days of recommendations to the restorative services to verify they have been implemented timely. A audit was completed by the DON to verify all dressings had been changed timely. Addendum: All of the residents had their Feb. MAR reviewed by the DON to verify that medications had been given as ordered. The measures put into place and a systemic change made to ensure the deficient practice does not recure is dietary staff has been inserviced by the Dietary Manger on 3/2/2012. Nursing staff and Department</p>				

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	<p>Parkinson's disease.</p> <p>A Physician's order dated 1/17/12, indicated the resident was to have derma sleeves to his right and left arm.</p> <p>A Physician's order dated 2/15/12, indicated the resident was to have a right arm half tray on his wheelchair for extremity positioning.</p> <p>The plan of care dated 10/25/11 and reviewed on 1/17/12, indicated the resident was at risk for falls related to the use of psychotropic drugs and unsteady gait. One of the listed interventions was for a wheelchair alarm.</p> <p>The plan of care dated 2/15/12, indicated the resident had a swollen right hand along with cellulitis to the hand. The interventions indicated the resident's hand was to be elevated as needed.</p> <p>Interview with LPN #1 on 2/20/12 at 11:40 a.m., indicated the resident was to have derma sleeves on bilaterally at all times except for care. She indicated the resident did not have a derma sleeve on either arm. She then asked CNA #2 to apply the derma sleeves. At that time, there was only one sleeve in the resident's drawer. The CNA indicated that she would have to clarify if the resident was</p>		<p>Heads have been in-serviced by DON/ SDC on 3/2-3/9/12 on following physician orders for restorative devices and timely dressing changes. Restorative Nurse has been by the Rehab Service Manager in regards to timely implementation of restorative services.</p> <p>Addendum: The DON and Medical Records Director will review all residents' MAR Mon – Fri for accuracy of medication administration. They will review all orders for labs Mon. – Fri. in change of condition meeting and verify that all the labs were completed as ordered. The evening supervisor will review all residents' food consumption records Mon. – Fri. to monitor for pattern of decrease of intake looking at three days at a time. To ensure the deficient practice does not recur, the monitoring system established is an audit will be completed on 50% of physician orders Mon – Fri (Weekend orders will be reviewed on Monday) by the DON/designee to verify that they have been processed properly. An audit will be completed 3 times per week (a different meal each time) on 50% of the meal trays by the Dietary Manager /designee to compare the accuracy of the tray to the tray card. The Rehab Service Manager will complete audits 2 times per week of 30% the residents who are on the</p>		

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	<p>to have a derma sleeve on his right arm due to the swelling.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/20/12 at 1:50 p.m., indicated the resident's half lap tray should have been in use to elevate the resident's right arm. Continued interview at the time, indicated there were conflicting interventions between the care plan and the Daily Care Guide related to the use of a chair alarm. She indicated there was no order for the chair alarm but it was listed as an intervention on the care plan. Continued interview at the time, indicated the order for the chair alarm should have been obtained since it was on the care plan and the chair alarm should have been in use.</p>		<p>restorative program to verify they are receiving restorative services and that care plans have been update to reflect services. A audit will be completed two times weekly by the ADON of 25% of the residents who receive dressing changes to verify dressings are being changed as ordered. Addendum: The Director of Clinical Services/designee will audit 30% of the MAR, labs, and food consumption records records 2 X weekly to verify compliance. The Executive Director will review 100% of the Dept. Head's audit of restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered three times per week. All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education.</p>		

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	<p>2. On 2/13/2012 at 12:33:41 p.m., Resident #G was observed wearing pink and white socks no non skid material on the bottom of her socks, and she was not wearing shoes.</p> <p>On 2/14/12 at 9:45 a.m., the resident was observed up in her w/c wearing socks with no non skid material and no shoes.</p> <p>On 2/15/12 at 9:10 a.m., 10:40 a.m., and 1:46 p.m., the resident was observed up in her wheelchair sitting by the Nurses' Station. At those times she was observed wearing plain blue striped fuzzy socks with no non skid material on the bottom of them. The resident was not wearing any shoes.</p> <p>The record for Resident #G was reviewed on 2/15/12 at 9:14 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease.</p> <p>Review of the current plan of care updated on 1/17/12 indicated the resident had the potential for falls related to vertigo(dizziness), cognitive deficit, and impaired safety awareness as evidenced by history of falls. The nursing approaches were to ensure the resident has and wears properly fitting non skid soled shoes for ambulation.</p>	F0282	<p>It is the practice e of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: Res #B is no longer in the facility. Res. #D had a follow up UA C&S with results 2/15 and 2/16. She received showers on 2/15 and 2/18/12, she was seen by the dietician on 2/16 and again on 3/1 with recommendation to add supplements to her POC. Resident F had Geri sleeves placed and arm was elevated by the CNA on 2/20/12. He had a clarification order written on 2/20 for use of a chair alarm and the Daily Care Guide reflects the order. Resident #G had non-skid socks applied. Resident H had restorative therapy initiated on 2/22/12 by the Restorative Nurse. Resident J received a dressing change by the wound care nurse on 2/17/12. Resident K had her dietary card audited to verify that it matches the PO. The Dietary Manager did verify that all items were received per tray card orders on 2/21/12. The corrective action taken for those residents having the potential to be affected by the same deficient practice is an audit was completed by the infection control nurse of physician orders over the last two weeks for UA's to verify they have been processed properly. The</p>	03/21/2012			

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	<p>Interview with CNA #5 on 2/15/12 at 9:54 a.m., indicated they have care card sheets with all the resident's information on it. She further indicated the resident has always worn those type of socks because that was all the types she had in her drawer. She further indicated there was no information regarding non skid sole socks or shoes on her card regarding resident #G.</p> <p>Interview with LPN #2 on 2/16/12 at 2:31 p.m., indicated the resident was wearing dark purple fuzzy slipper socks and there were no non skid soles on them.</p> <p>3. The record for Resident #H was reviewed on 2/17/12 at 12:55 p.m. The resident was admitted to the facility on 9/28/11 from the hospital. The resident's diagnoses included, but were not limited to, dementia, hypotension, arthritis, COPD(chronic obstructive pulmonary disease), emphysema, Parkinson disease, and organic brain syndrome.</p> <p>Review of Physician Orders dated 2/2/12 indicated Restorative therapy: AROM (active range of motion) to bilateral upper extremity hand bike times 15 minutes sit to stand 3 minutes times 5 sets, standing tolerances. PROM (passive range of motion) to bilateral upper extremities 20 repetitions times 2 sets.</p>		<p>dietician to verify that the tray cards matched physician orders for supplements completed a house wide audit. The department heads to completed a house wide audit of the residents to verify that restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered were in proper place. Nursing management competed a house wide audit to verify that the care guides and care plans matched. A audit was completed by the Rehab Service Manager of the last 30 days of recommendations to the restorative services to verify they have been implemented timely. A audit was completed by the DON to verify all dressings had been changed timely. Addendum: All of the residents had their Feb. MAR reviewed by the DON to verify that medications had been given as ordered. The measures put into place and a systemic change made to ensure the deficient practice does not recure is dietary staff has been inserviced by the Dietary Manger on 3/2/2012. Nursing staff and Department Heads have been in-serviced by DON/ SDC on 3/2-3/9/12 on following physician orders for restorative devices and timely dressing changes. Restorative Nurse has been by the Rehab Service Manager in regards to</p>		

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	<p>Further review of Physician Orders dated 1/30/12 indicated Restorative therapy: BLE (bilateral lower extremity) leg bike times 20 minutes with 2 pound weights, bed to wheelchair transfers times 5 sets and ambulate 70 feet times 2, gait belt and CNA.</p> <p>Review of the Restorative Nursing Program Flow Sheet for the week of 1/29-2/4/12 indicated the resident did not receive any therapy 1/29/12 - 1/31/12 and 2/1/12- 2/4/12.</p> <p>Review of the Restorative Nursing Program Flow Sheets for the week of 2/5-2/11/12 and 2/12/12-2/18/12 indicated the resident did not receive therapy on 2/7/12- 2/9/12, 2/11/12-2/14/12, 2/16/12-2/18/12.</p> <p>Interview with the Assistant Director of Nursing on 2/20/12 at 12:17 p.m., indicated the resident did not receive Restorative Therapy as ordered by the Physician.</p> <p>4. On 2/16/12 at 3:15 p.m., the medication drawer for Resident #B was observed. At that time, the medication of Tovaz (a medication used for urinary spasms) was reviewed. The pharmacy had sent the facility a total of 30 pills on</p>		<p>timely implementation of restorative services. Addendum: The DON and Medical Records Director will review all residents' MAR Mon – Fri for accuracy of medication administration. They will review all orders for labs Mon. – Fri. in change of condition meeting and verify that all the labs were completed as ordered. The evening supervisor will review all residents' food consumption records Mon. – Fri. to monitor for pattern of decrease of intake looking at three days at a time. To ensure the deficient practice does not recur, the monitoring system established is an audit will be completed on 50% of physician orders Mon – Fri (Weekend orders will be reviewed on Monday) by the DON/designee to verify that they have been processed properly. An audit will be completed 3 times per week (a different meal each time) on 50% of the meal trays by the Dietary Manager /designee to compare the accuracy of the tray to the tray card. The Rehab Service Manager will complete audits 2 times per week of 30% the residents who are on the restorative program to verify they are receiving restorative services and that care plans have been update to reflect services. A audit will be completed two times weekly by the ADON of 25% of the residents who receive</p>				

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	<p>2/10/12. There were 27 pills left in the box on 2/16/12.</p> <p>The record for Resident #B was reviewed on 2/16/12 at 1:19 p.m. The resident was admitted to the facility on 2/10/12 from the hospital.</p> <p>Review of the Medication Administration Record (MAR) dated 2/10/12 indicated Tovaz 8 mg was only signed out as being given on 2/13/12. The time of administration indicated 8:30 there was no a.m. or p.m. handwritten next to it.</p> <p>Interview with LPN #2 at that time, indicated the medication had only been given three times since the resident had been at the facility. She further indicated the medication had been missed for at least three days.</p> <p>5. The record for Resident #D was reviewed on 2/15/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, knee joint replacement, senile dementia, high blood pressure, depressive disorder, and convulsions.</p>		<p>dressing changes to verify dressings are being changed as ordered. Addendum: The Director of Clinical Services/designee will audit 30% of the MAR, labs, and food consumption records records 2 X weekly to verify compliance. The Executive Director will review 100% of the Dept. Head's audit of restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered three times per week. All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education.</p>				

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	<p>A Physician's order was written on 1/12/12 to obtain a Urinalysis and Culture & Sensitivity to be completed by the laboratory. Another order was written on 1/17/12 for staff to straight catheterize the resident for the Urinalysis and Culture and Sensitivity test.</p> <p>The 1/2012 Laboratory test results were reviewed. There was no documentation the ordered Urinalysis and Culture and Sensitivity had been completed by the facility.</p> <p>The resident's care plans were reviewed. There was a care plan indicating the resident had an alteration in nutritional status related to decreased oral intake. The care plan was initiated on 5/10/2010 and last updated on 12/20/11. Care plan interventions included to monitor the resident's intake. There was also a care plan indicating the resident was at risk for skin breakdown. The care plan was initiated on 12/20/11. Care plan interventions included for staff to record the resident's food intake percentage at each meal.</p> <p>A care plan initiated on 1/11/12 indicated the resident refused showers at times. Care plan interventions included for staff to call the resident's sister when showers</p>						

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	<p>were refused. A care plan initiated on 8/8/11 indicated the resident refused showers and for staff to wash her clothes. The care plan was last updated on 12/20/11. Care plan interventions included for staff to call the resident's sister to encourage her.</p> <p>The 2/2012 electronic generated Diet Monthly Flow Report was reviewed. The amount of the resident's meal intake was not recorded for the breakfast and lunch meals on 2/1/12 thru 2/3/12 and 2/11/12. The amount of the resident's meal intake was not recorded for the breakfast meals on 2/6/12 and 2/12/12. The amount of the resident's meal intake was not recorded for the lunch meal on 2/8/12.</p> <p>The 1/2012 and the 2/2012 electronic generated Daily Care Monthly Flow Reports were reviewed. The 1/2012 report indicated the resident refused bathing on 1/5/12, 1/6/12, 1/9/12, 1/10/12, 1/17/12, 1/23/12, and 1/27/12. The 2/2012 report indicated the resident refused bathing on 2/7/12.</p> <p>The 1/2012 and the 2/2012 Nurses' Notes were reviewed. There was no indication the staff called the resident's sister related to the refusals as per her plan of care.</p>						

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	<p>When interviewed on 2/20/12 at 10:15 a.m., the Assistant Director of Nursing indicated the CNA's write down the intake amount of each meal on the tray card slip and then enter the amount into the computer for each meal. The Assistant Director of Nursing indicated the slips are then thrown away and there is no other area of documentation of the meal intakes.</p> <p>When interviewed on 2/20/12 at 10:30 a.m., the Director of Nursing indicated the resident's plan of care was not followed related to monitoring the resident's oral intakes.</p> <p>When interviewed on 2/16/2012 at 12:03 p.m., the Director of Nursing indicated if the resident refused the shower staff were to call the resident's sister to come in to attempt to encourage the resident to accept the shower. Nursing staff were to document attempts to call the resident's sister in the Nurses' Notes as per the resident's plan of care.</p> <p>When interviewed on 2/15/12 at 11:07 a.m., the Assistant Director of Nursing indicated an order was obtained for a Urinalysis and Culture and Sensitivity on 1/12/12. The Assistant Director of Nursing indicated the ordered urine specimen had not been collected until the</p>						

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	<p>resident was sent to the hospital on 1/27/12.</p> <p>6. Resident #K was observed on 2/16/12 at 12:50 p.m. The resident was in bed, her lunch had been served. The resident did not receive pudding on her lunch tray.</p> <p>The resident was observed on 2/17/12 at 12:48 p.m. in bed. Her lunch tray was served to her in her room. There was no soup served with her lunch</p> <p>On 2/19/12 at 8:36 a.m. the resident's breakfast was served. There was no orange supplement drink on the resident's breakfast tray. Interview with LPN #2 at that time, indicated there was no orange supplement drink served on the resident's breakfast tray.</p> <p>The record for Resident #K was reviewed on 2/15/12 at 9:04 a.m. The resident had diagnoses that included, but were not limited to, congestive heart failure, diabetes, and osteoarthritis.</p> <p>The February 2012 Physician Order Sheet was reviewed, it indicated the resident's diet was: regular, whole milk with all meals and pudding with meals, orange supplement drink at breakfast, super soup at lunch and dinner, 2 Cal (a nutritional</p>						

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	<p>supplement) 90 milliliters twice daily.</p> <p>LPN #2 was interviewed on 2/20/12 at 8:46 a.m. She indicated there was no orange supplement available from the kitchen to give to the resident. She also indicated there was a physician's order that the resident was to receive super soup (a dietary supplement) at lunch and dinner and she was to receive pudding with meals. She indicated the Physician's orders for the dietary supplements were not followed.</p> <p>The Dietary Manager was interviewed on 2/20/12 at 10:25 a.m. She indicated there was no orange supplement drink available in the kitchen for the breakfast meal. She indicated a supply of the orange supplement was ordered and would be coming to the facility at lunch time.</p> <p>7. Resident #J was observed on 2/15/12 at 8:45 a.m. She was seated in a wheelchair in the dining room, there was a dressing on her left lower leg dated 2/15/12.</p> <p>The resident was observed on 2/16/12 at 10:00 a.m. seated in a wheelchair in the Therapy Room. There was a dressing on her left leg dated 2/15/12.</p> <p>The resident was again observed on</p>						

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	<p>2/17/12 at 10:58 a.m. She was seated in her wheelchair in front of the 200 unit nurse's station. There was a dressing on her left leg dated 2/15/12.</p> <p>On 2/17/12 at 1:15 p.m., the dressing on the resident's left leg was observed. The dressing was dated 2/17/12 and had LPN #2's initials.</p> <p>LPN #2 was interviewed on 2/17/12 at 1:32 p.m., she indicated the resident's dressing was loose and she reinforced the dressing. She stated she did not do a complete dressing change because the Wound Nurse was coming in to complete the treatment. She indicated the dressing she removed was dated 2/15/12.</p> <p>The record for Resident #J was reviewed on 2/17/12 at 12:51 p.m. The resident had diagnoses that included, but were not limited to, hypertension, anemia and coronary artery disease.</p> <p>Review of the Non-Pressure Skin Condition Record indicated the resident had a skin tear that was first noted on 2/3/12 to the left lower leg.</p> <p>There was a Physician's order dated 2/7/12 that indicated, "1) left lateral lower leg, D/C (discontinue) Silvadene cream to area and start 2). Left lateral leg, cleanse</p>						

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	<p>area with n/s (normal saline) pat dry and apply Santyl and Calcium Arginate dressing, cover with Kerlix wrap daily and prn (as needed)."</p> <p>Continued interview with LPN #2 on 2/17/12 at 1:32 p.m., indicated there was a physician's order to change the dressing daily. She indicated the treatment to the skin tear was not completed daily as ordered by the Physician. The LPN also indicated the dressing should have been changed on 2/16/12 and dated 2/16/12.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</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 derma sleeves were in place, an upper extremity was elevated and a treatment was completed as ordered for 2 of 3 residents of the 9 who met the criteria for non-pressure skin conditions. (Residents #F and #J)</p> <p>Findings include:</p> <p>1. On 2/15/12 at 8:30 a.m., Resident #F was observed seated in his wheelchair in his room. The resident was observed with edema to his right hand. The resident's right hand was red in the knuckle area. At 10:15 a.m. and 11:20 a.m., the edema and redness remained to the resident's right hand. At 1:00 p.m., the resident's right hand was elevated on a pillow and a 1/2 lap tray had been added to the resident's wheelchair.</p> <p>During observation on 2/16/12 at 8:35 a.m., the resident was observed in his room in bed. The resident was wearing a</p>	F0309	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: Resident F had Geri sleeves placed and arm elevated by the CNA on 2/20/12. He had a clarification order written on 2/20 for use of a chair alarm and the Daily Care Guide reflects the order. Resident J received a dressing change by the wound care nurse on 2/17/12. The corrective action taken for those residents having the potential to be affected by the same deficient practice is the department heads to verify that restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered were in proper place. An audit was completed by the DON to verify all dressings had been changed timely. The measures put into place and a systemic change made to ensure the deficient practice does not</p>	03/21/2012			

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	<p>short sleeve shirt and he had no derma sleeve in place to the left arm. The resident's right arm was wrapped with a gauze dressing. At 9:20 a.m., the resident was seated in a wheelchair in his room. The resident's right hand remained red and swollen. The resident's right arm was not elevated at this time. At 12:11 p.m., the resident's right hand remained edematous with redness. The 1/2 lap tray was not in use at this time, nor was the resident's right arm elevated.</p> <p>On 2/17/12 at 8:29 a.m., the resident was seated in his wheelchair in the Restorative Dining Room. The resident's right arm was not elevated. The resident's right hand remained edematous and red in color.</p> <p>On 2/20/12 at 8:30 a.m., 9:30 a.m., and 11:30 a.m., the resident was seated in a wheelchair in his room. The resident's right hand remained red with some edema. The resident's hand was not elevated at this time. Further, the resident did not have on derma sleeves to either hand.</p> <p>The record for Resident #F was reviewed on 2/15/12 at 8:45 a.m. and on 2/17/12 at 8:35 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, dementia and</p>		<p>reoccur is Nursing staff and Department Heads have been in-serviced by DON/ SDC on 2/24-3/9/12 on following physician orders for restorative devices and timely dressing changes. To ensure the deficient practice does not recur, the monitoring system established is a audit will be completed two times weekly by the ADON of 25% of the residents who receive dressing changes to verify dressings are being changed as ordered.</p> <p>Addendum: The Executive Director will review 100% of the Dept. Head's audit of restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered three times per week. All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education.</p>				

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	<p>Parkinson's disease.</p> <p>A Physician's order dated 1/17/12, indicated the resident was to have derma sleeves to his right and left arm.</p> <p>A Physician's order dated 2/15/12, indicated the resident was to have a right arm half tray on his wheelchair for extremity positioning.</p> <p>The plan of care dated 2/15/12, indicated the resident had a swollen right hand along with cellulitis to the hand. The following interventions were listed:</p> <ul style="list-style-type: none"> -elevate hand as needed -antibiotic as ordered -monitor for increased redness and pain -notify the physician of any significant changes. <p>Interview with LPN #1 on 2/20/12 at 11:40 a.m., indicated the resident was to have derma sleeves on bilaterally at all times except for care. She indicated the resident did not have a derma sleeve on either arm.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/20/12 at 1:50 p.m., indicated the resident's half lap tray should have been in use to elevate the resident's right arm.</p>				

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	<p>2. Resident #J was observed on 2/15/12 at 8:45 a.m. She was seated in a wheelchair in the Dining Room, there was a dressing on her left lower leg that was dated 2/15/12.</p> <p>The resident was observed on 2/16/12 at 10:00 a.m. seated in a wheelchair in the therapy room. There was a dressing on her left leg dated 2/15/12.</p> <p>The resident was again observed on 2/17/12 at 10:58 a.m. She was seated in her wheelchair in front of the 200 unit nurse's station. There was a dressing on her left leg dated 2/15/12.</p> <p>On 2/17/12 at 1:15 p.m., the dressing on the resident's left leg was observed. The dressing was dated 2/17/12 and had LPN #2's initials.</p> <p>Interview with LPN #2 on 2/17/12 at 1:32 p.m., indicated the resident's dressing was loose and she reinforced the dressing. She stated that she did not do a complete dressing change because the Wound Nurse was coming in to complete the treatment. She indicated the dressing she removed was dated 2/15/12.</p> <p>On 2/17/12 at 2:48 p.m., wound care to</p>						

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	<p>the left leg was observed. The Wound Nurse removed the dressing to left leg. The wound had yellow slough and was red around the edges. The area measured 6 by 5 cm (centimeters) in size. The wound nurse completed the treatment and applied a dressing that she dated 2/17/12.</p> <p>The record for Resident #J was reviewed on 2/17/12 at 12:51 p.m. The resident had diagnoses that included, but were not limited to, hypertension, anemia, and coronary artery disease.</p> <p>Review of the Non-Pressure Skin Condition Record indicated the resident had a skin tear that was first noted on 2/3/12 to the left lower leg. The area was 5.5 x 2.8 cm is size when first observed.</p> <p>On 2/6/12 the area was 7 x 4 cm in size with an undetermined depth. On 2/8/12 the area was 6 x 5 cm and undetermined depth On 2/15/12 the area was 6 x 5 cm and undetermined depth</p> <p>There was a Physician's order dated 2/7/12 that indicated, "1) left lateral lower leg, D/C (discontinue) Silvadene cream to area and start 2). Left lateral leg, cleanse area with n/s (normal saline) pat dry and apply Santyl and Calcium Arginate dressing, cover with Kerlix wrap daily</p>						

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	<p>and prn (as needed)."</p> <p>LPN #2 was interviewed on 2/17/12 at 1:32 p.m. She indicated there was a Physician's order to change the dressing daily. She indicated the treatment to the skin tear was not completed daily as ordered by the Physician. She indicated the dressing should have been changed on 2/16/12.</p> <p>3.1-37(a)</p>			

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS 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 resident's who were discharged from Rehabilitation received the appropriate services to attain or maintain their level of function related activities of daily living for 1 of 3 residents reviewed for rehabilitation of the 23 residents who met the criteria for rehabilitation. (Resident #H)</p> <p>Findings include:</p> <p>The record for Resident #H was reviewed on 2/17/12 at 12:55 p.m. The resident was admitted to the facility on 9/28/11 from the hospital. The resident diagnoses included, but were not limited to, dementia, hypotension, arthritis, COPD(chronic obstructive pulmonary disease, emphysema, Parkinson's disease, and organic brain syndrome.</p> <p>Review of Physical and Occupational Therapy notes indicated the resident received services from 9/28-12/30/11.</p> <p>Further review of the therapy notes</p>	F0311	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:The corrective action taken for the residents found to have been affected by the deficient practice was the Restorative Nursing Program Assessment plan for resident H was reviewed by a licensed therapist and the restorative nurse to ensure the treatment plan was current and reflective of current resident need. The restorative program was re-instituted according to the updated assessment and documented on the restorative nursing flow record.The corrective action taken for those residents having the potential to be affected by the same deficient practice is the Restorative Nursing Program Assessment Plans for all residents receiving services were reviewed by a licensed therapist and the restorative nurse to ensure the treatments plans are current and reflective of resident needs. The restorative service for each resident will be conducted according to the current assessment and documented on</p>	03/21/2012	

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	<p>indicated on 1/3/12 the resident was referred again to Physical Therapy and Occupational Therapy for having functional decline from prior level of care and function secondary to his medical condition and orthostatic hypotension. Both therapies concurred the resident was at risk for further deterioration of functional mobility unless skilled Physical and Occupational series were not provided.</p> <p>The resident received the therapy services from 1/3-1/31/12 in which he was discontinued from both Physical and Occupational therapy and referred to the Restorative Program.</p> <p>Review of the initial Minimum Data Set (MDS) assessment dated 10/4/11 indicated the resident needed extensive assist with a one person physical assist with bed mobility and transfers, and locomotion on and off the unit.</p> <p>Review of the quarterly MDS dated 12/27/11 indicated the resident required extensive assist with a two person assist physical assist with bed mobility, transfer, locomotion on and off unit, dressing, eating, and personal hygiene.</p> <p>The MDS indicated there was a decline in transfers and bed mobility from the initial</p>		<p>the Restorative Nursing flow record. The measures put into place and a systemic change made to ensure the deficient practice does not recur is Dedicated staff have been assigned to the restorative program staffing along with assigned back-up's in their absence to ensure that restorative therapy occurs as scheduled. No restorative staff will be performing other facility duties without the authorization of the Executive Director to ensure a back up staff member will be available to perform restorative services. To ensure the deficient practice does not reoccur, the monitoring system established is a Performance Improvement indicator has been established. The Rehab Service Manager will complete audits 2 times per week of 30% the residents who are on the restorative program to verify they are receiving restorative services and that care plans have been updated to reflect services. The Rehab Service Manager or her designee will complete the indicator weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution</p>		

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	<p>assessment to the quarterly assessment.</p> <p>Review of Physician Orders dated 2/2/12 indicated Restorative therapy: AROM (active range of motion) to bilateral upper extremity hand bike times 15 minutes sit to stand 3 minutes times 5 sets, standing tolerances. PROM (passive range of motion) to bilateral upper extremities 20 reps times 2 sets.</p> <p>Further review of Physician Orders dated 1/30/12 indicated Restorative therapy: BLE (bilateral lower extremity) leg bike times 20 minutes with 2 pound weights, bed to wheelchair transfers times 5 sets and ambulate 70 feet times 2 gait belt and CNA.</p> <p>Review of the Restorative Nursing Program Assessment Plan indicated dated 1/30 and 2/1/12 indicated the resident was receive restorative services six times a week that included ambulation, bike therapy for his legs and hands, passive and active range of motion as well as wheelchair transfers to the bed and chair.</p> <p>Review of the Restorative Nursing Program Flow Sheet for the week of 1/29-2/4/12 indicated the resident did not receive any therapy 1/29/12 - 1/31/12 and 2/1/12- 2/4/12.</p>						

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	<p>Review of the Restorative Nursing Program Flow Sheets for the week of 2/5-2/11/12 and 2/12/12-2/18/12 indicated the resident did not receive therapy on 2/7/12- 2/9/12, 2/11/12-2/14/12, 2/16/12-2/18/12.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/20/12 12:17 p.m., indicated she just started this position about one month ago and had no previous experience with restorative. She further indicated there are currently two Restorative CNAs that work with her, and there was only one here today. She indicated the facility was very challenged the last couple of weeks with CNA help and there were no restorative aide to do the work and complete the Restorative Therapy for the resident. She further indicated there were about 20 residents on Restorative Therapy currently and the staffing for restorative was based on the census and sometimes when there was only one CNA to do the Restorative therapy it does not always get done everyday.</p> <p>Interview with Restorative CNA #4 on 2/20/12 at 12:30 p.m., indicated that often the restorative CNA gets pulled to floor and restorative does not get done. She indicated that Resident #H does not get restorative therapy everyday as ordered</p>			

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	<p>especially if they get pulled to the floor and if there was only one restorative CNA on duty. She indicated she was the only one here today and some of the resident receiving restorative therapy will not get done.</p> <p>3.1-38(a)(2)(B)</p>				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</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 provide the necessary services to maintain nutrition related to not being supervised with meals for 1 of 2 residents reviewed for ADL (Activities of Daily Living) assistance in the Stage 2 sample of 35. (Resident #D)</p> <p>Finding include:</p> <p>On 2/16/12 at 8:38 a.m., CNA #1 was observed passing breakfast meal trays down Resident #D's hall. At 8:44 a.m. the CNA entered the resident's room with her meal tray and placed the tray on the resident's over bed table and left the room. The resident was seated in a wheel chair. The resident picked up the spoon with her left hand and tried to put the spoon into her right hand to eat her yogurt. The spoon was not placed correctly in her right hand. The resident had picked up the carton of yogurt with her left hand and was not able to put the spoon into the yogurt so she put the yogurt container back on the tray without eating any at this time. After about one</p>	F0312	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was resident D is assisted with meals in her room and encouraged to consume meals in the assisted dining room for closer observation. Physician to be notified with a 5 pound weight loss or gain. The corrective action taken for those residents having the potential to be affected by the same deficient practice is Medical records of residents with physical impairments will be reviewed for appropriate supervision during meal times. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing staff have been re-educated by DON/SDC on 3/2-3/9 for appropriate supervision and interventions during meal times To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit 25% of the residents who remain in rooms 3 times weekly</p>	03/21/2012	

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	<p>minute the resident pushed the overbed table away from her and started propelling herself in the wheel chair towards her bed. At 8:50 a.m., CNA #1 re entered the room and tried to give the resident bites of the yogurt and cereal and the resident told the CNA she did not want any.</p> <p>On 2/16/12 at 9:05 a.m., the Assistant Director of Nursing was observed assessing the resident's movement of her upper extremities. The resident had a spoon in her left hand and had difficulty taking the spoon from her left hand and placing it in her right hand on her own. The fingers of the resident's right hand were bent closed in a fist and the resident pushed the spoon in between the thumb and the right first finger without opening the fingers.</p> <p>On 2/16/12 at 1:07 p.m., the resident was observed in bed eating lunch. There were no staff in the resident's room. The resident was observed picking up carrots with her left hand. At this time the resident was observed using the spoon in her right hand to eat sherbet.</p> <p>The record for Resident #D was reviewed on 2/15/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, senile dementia, high blood pressure, osteoarthritis, cerebral vascular accident</p>		(each meal time to be audited) to ensure they are assisted when needed. DON/designee will monitor the restorative dining room daily at each mealtime to ensure residents have supervision and interventions in place. DON/designee will complete these indicators weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution..		

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	<p>(stroke), and depressive disorder.</p> <p>The 2/2012 Nurses' Notes were reviewed. An entry made on 2/10/12 at 10:00 a.m. indicated the daughter noted the residents right dominant hand was partially clenched and was making it difficult to grasp or hold items. The daughter also indicated even though the resident may say she does not want to eat, she will with encouragement. The entry also indicated a message was left to place the resident in the restorative part of the dining room so the resident would be monitored/encouraged or fed as needed.</p> <p>The 1/2012 Nurses' Notes were reviewed. There was no documentation the physician was notified of the residents decreased food consumption 1/22/12 thru 1/27/12. An entry made on 1/27/12 at 2:30 p.m. indicated the resident's daughter voiced concerns related to the resident's lethargy. The entry also indicated the resident was moving around very little and not drinking. The next entry was made on 1/27/12 at 8:00 p.m. This entry indicated the resident was being transferred to the hospital for evaluation and treatment.</p> <p>The 1/27/12 hospital Emergency Department notes indicated the resident had decreased oral intake and infection.</p>				

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	<p>The note also indicated the resident was asking for something to drink. The note also indicated the Nursing Home staff indicated the resident did not eat or drink water for two days.</p> <p>The resident's care plans were reviewed. There was a care plan indicating the resident had an alteration in nutritional status related to decreased oral intake. The care plan was initiated on 5/10/2010 and last updated on 12/20/11. Care plan interventions included to monitor the resident's intake. There was also a care plan indicating the resident was at risk for skin breakdown. The care plan was initiated on 12/20/11. Care plan interventions included for staff to record the resident's food intake percentage at each meal.</p> <p>The 2011 and 2012 Weight Records indicated the following weights were recorded: 09/10/11 207.10 pounds 10/10/11 203 pounds 11/08.11 204.10 pounds 12/09/11 203 pounds 01/10/12 201.9 pounds 02/07/12 184 pounds 02/15/12 185 pounds</p> <p>When interviewed on 2/16/12 at 9:19 a.m., the Assistant Director of Nursing</p>				

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	<p>indicated she asked Therapy to screen the resident on 2/10/12 and the resident refused. The Assistant Director of Nursing indicated on 2/10/12 the resident was noted to have decreased use of her right dominant hand with her meals and was to be placed in the Restorative side of the dining room as the resident could be supervised with her meals.</p> <p>3.1-38(a)(2)(D)</p>			

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F0315 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 record review and interview, the facility failed to provide the necessary treatment and services related to not obtaining a urine specimen for a urinalysis laboratory test to be completed for a resident with a urinary tract infection in a timely manner which resulted in the delay of treatment for 1 of 3 resident's reviewed for urinary tract infections in the Stage II sample of 35. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 2/15/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, dysuria (difficulty urinating), senile dementia, depressive disorder, high blood pressure, and convulsions.</p> <p>A Physician's order was written on</p>	F0315	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was resident D's antibiotic treatment continues and a follow up Urinalysis and Culture and Sensitivity has been conducted with no additional treatment indicated. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: A complete review of all residents physicians orders for Urinalysis and Culture and Sensitivity for the last 14 days has been conducted to ensure that no outstanding orders exist and that all specimens have been collected in accordance with orders. The measures put into place and systemic change made to ensure the deficient practice does not</p>	03/21/2012			

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	<p>1/12/12 to obtain a Urinalysis and Culture & Sensitivity to be completed by the laboratory. Another order was written on 1/17/12 for staff to straight catheterize the resident for the Urinalysis and Culture and Sensitivity test. A Physician's order was written on 1/27/12 to send the resident to the hospital for an evaluation and treatment. An order was written on 1/28/12 for the resident to receive Cipro (an antibiotic) 500 milligrams twice a day for 10 days. An order was written on 1/30/12 to discontinue the Cipro and to start Macrobid (an antibiotic) 100 milligrams twice a day for 7 days.</p> <p>The 1/2012 Laboratory test results were reviewed. There was no documentation the ordered Urinalysis and Culture and Sensitivity had been completed by the facility.</p> <p>The 1/2012 Nurses' Notes were reviewed. An entry made on 1/12/12 at 5:00 p.m. indicated a new order was received to obtain a Urinalysis and Culture and Sensitivity due to a complaint the resident was not feeling well. There was no further documentation related to the ordered urine tests in the Nurses' Notes from 1/12/12 thru 1/15/12. An entry made on 1/16/12 at 11:00 a.m. indicated an order was received indicating staff</p>		<p>reoccur is: As a portion of Monday through Friday change of condition meeting all physician orders will be reviewed to ensure timely and appropriate follow through and specimen collection. To ensure the deficient practice does not reoccur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with the timely collection of specimens and completion of Urinalysis and Culture and Sensitivity in accordance with physician order. The Infection Control Nurse or designee will complete an audit 2 times weekly of 50% of the residents with orders for a UA/C&S. Infection Control Nurse or designee will complete these indicators weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>				

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	<p>may straight catheterize the resident to obtain the urine specimen for the Urinalysis and Culture & Sensitivity laboratory test. An entry made on 1/17/12 at 7:00 p.m. indicated staff were unable to obtain to catheterize the resident due to redness and irritation. The next entry was made on 1/18/12 at 11:00 p.m. and this entry indicated staff were still awaiting the Urinalysis and Culture and Sensitivity. There were no further entries related the ordered urine laboratory tests in the Nurses' Notes from 1/18/12 thru 1/27/12. An entry made on 1/27/12 at 2:30 p.m. indicated the resident's daughter expressed concerns related to the resident's lethargy and thought the resident may have a urinary tract infection. An entry made on 1/27/12 at 8:00 p.m. indicated the family member preferred the resident be sent to the hospital.</p> <p>An entry made on 1/28/12 at 3:55 a.m. indicated the resident returned to the facility with the diagnoses of urinary tract infection and a prescription for Cipro (an antibiotic) 500 milligrams twice a day for 10 days. An entry was made in the Nurses' Notes on 1/30/12 at 10:50 a.m. This entry indicated the hospital Nurse called the facility to notify then the final results of the Urine Culture and Sensitivity indicated the organism was resistant to Cipro.</p>			

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	<p>The 1/27/12- 1/28/12 hospital records were reviewed. A Physical Exam report indicated a urinalysis was positive for nitrates, a small amount of leukocytes.</p> <p>When interviewed on 2/15/12 at 11:07 a.m., the Assistant Director of Nursing indicated an order was obtained for a Urinalysis and Culture and Sensitivity on 1/12/12. The Assistant Director of Nursing indicated the ordered urine specimen had not been collected until the resident was sent to the hospital on 1/27/12. The Assistant Director of Nursing indicated the resident returned from the hospital with a urinary tract infection.</p> <p>3.1-41(a)(2)</p>			

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</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 a gastrostomy tube flush was completed before and after gastrostomy tube medication administration for 1 of 1 gastrostomy tube medication administrations observed. (Resident #28) (RN #1)</p> <p>Findings include:</p> <p>On 2/16/12 at 4:28 p.m., RN #1 was observed preparing Potassium Chloride (a potassium supplement) for Resident #28. The medication was to be administered by the way of the resident's gastrostomy tube. The RN proceeded to check the placement of the resident's tube and then administer the Potassium Chloride. The RN did not flush the gastrostomy tube with water prior to or after giving the medication.</p>	F0322	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was resident #28 no longer resides in the facility. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents of the nursing center with enteral feeding tubes have the potential to be affected, therefore, this plan of correction applies to all residents with enteral feeding tubes. The measures put into place and systemic change made to ensure the deficient practice does not reoccur is: Licensed nursing staff have been in-serviced by DON/SDC on 3/2-3/9/12 related to care of enteral feeding tubes, including but not limited to water flushes according to physician order. Licensed nurses will complete a</p>	03/21/2012			

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	<p>Interview with RN #1 at the time, indicated that she should have flushed the resident's tube with water before and after giving the medication.</p> <p>The record for Resident #28 was reviewed on 2/20/12 at 3:05 p.m. A Physician's order originally dated 11/15/11 and on the February 2012 Physician's Order Summary (POS), indicated the resident was to receive Potassium Chloride 20%, 40 milliequivalents (meq)/15 milliliters (mls) by the way of the gastrostomy tube four times a day.</p> <p>The facility policy titled "Feeding Tube-Instilling Medication" was reviewed on 2/20/12 at 10:15 a.m. The policy was provided by the Director of Nursing and identified as current.</p> <p>The policy indicated the following:</p> <ul style="list-style-type: none"> -Flush with 30 cc water prior to medication administration -Insert medication by syringe slowly into tube. -Flush with 30 cc of water. <p>3.1-44(a)(2)</p>		<p>competency check off with return demonstration to ensure proper technique by the SDS by 3/19/2012. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with proper technique for water flushes according to physician order. The Staff Development Coordinator, or designee, shall observe enteral feeding tube procedures for at least 50% of residents who have enteral tubes 2 times per week. The indicator will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure a chair alarm was in place for 1 of 3 residents of the 8 who met the criteria for accidents. (Resident #F)</p> <p>Findings include:</p> <p>On 2/20/12 at 8:30 a.m., 9:30 a.m., 11:30 a.m. and 1:30 p.m., Resident #F was observed seated in his room in a wheelchair. There was no chair alarm in use.</p> <p>The resident's record was reviewed on 2/15/12 at 8:45 a.m. and on 2/17/12 at 8:35 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>A Fall Risk Assessment dated 10/10/11 and 11/18/11, indicated the resident scored a "20", indicating he was a high risk for falls. Interventions implemented at the time were low bed, floor mat, chair and bed alarm.</p>	F0323	<p>It is the practice of this facility to ensure the highest quality of care is afford our residents. Consistent with this practice, the following has been done:The corrective action taken for the resident found to have been affected by the deficient practice was resident F was reassessed for falls, chair alarm was placed during survey. Care plan and care delivery guide was updated on 2/20/12 by DON to reflect current status. The corrective action for those residents having the potential to be affected by the same deficient practice is medical records and physician order sheets will be reviewed for accuracy related to assisted devices. Care plans and care delivery guides have also been reviewed and updated to reflect current status.The measures put into place and a systemic change made to ensure the deficient practice does not reoccur Nursing staff will be reeducated regarding appropriate devices are in place by the DON/SDC on 3/2-3/9/12. The department heads to verify that restorative devices are in proper place, that the care guides and care plans matched will complete</p>	03/21/2012			

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	<p>The Fall Risk Assessments dated 1/7, 1/11, and 1/12/12, indicated the resident scored a "22", indicating he was a high risk for falls.</p> <p>An Initial Minimum Data Set (MDS) Assessment dated 10/17/11, indicated the resident was extensive assist with transfers.</p> <p>The Quarterly MDS Assessment dated 1/27/12, indicated the resident remained extensive assist with transfers and that he had a fall since the prior assessment. The resident had one fall with no injury and one fall with injury (except major).</p> <p>The plan of care dated 10/25/11 and reviewed on 1/17/12, indicated the resident was at risk for falls related to the use of psychotropic drugs and unsteady gait. One of the listed interventions was for a wheelchair alarm.</p> <p>The Care Plan Conference Record dated 1/17/12, indicated the resident was a fall risk and would occasionally make attempts to self transfer.</p> <p>Review of the Daily Care Guide on 2/20/12 at 10:37 a.m., indicated the resident was to utilize a bed alarm, low bed, and body pillows.</p>		<p>house wide auditsTo ensure the deficient practice does not reoccur, the monitoring system established is The Executive Director will review the Dept. Head's continued audits of assistive devices at morning meeting. All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education.</p>		

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	<p>Interview with LPN #1 on 2/20/12 at 11:40 a.m., indicated based on the Daily Care Guide, the resident was to have a low bed with mat, bed alarm, and body pillows.</p> <p>Interview with CNA #1 on 2/20/12 at 1:40 p.m., indicated the resident had a bed alarm but not a chair alarm. She indicated she would put the resident's chair alarm on in the past, but it would keep getting removed. She indicated the chair alarm was not listed on the Daily Care Guide.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/20/12 at 1:50 p.m., indicated there were conflicting interventions between the care plan and the Daily Care Guide related to the use of a chair alarm. She indicated there was no order for the chair alarm but it was listed as an intervention on the care plan. Continued interview at the time, indicated the order for the chair alarm should have been obtained since it was on the care plan and the chair alarm should have been in use.</p> <p>3.1-45(a)(2)</p>				

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F0441 SS=D	<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, record review and interview, the facility failed to ensure</p>	F0441	It is the practice of this facility to ensure the highest quality of care	03/21/2012	

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	<p>hand washing was completed after the removal of gloves and the donning of gloves was completed before administering an injection for 1 of 1 observation of an injection and for 1 of 1 observation of a glucometer check of the stage 2 sample of 35. (Residents #C & #14) (LPN #2 & LPN #3)</p> <p>Findings include:</p> <p>1. On 2/15/12 at 8:43 a.m., Resident #C was observed in bed eating breakfast. At that time LPN #3 was observed pouring Resident C's medication. The LPN pulled a vial of Heparin (a blood thinning medication) 5000 units out of the resident's medication drawer. She then gathered her supplies of an alcohol pad and syringe and entered the resident's room. The LPN drew up the Heparin into the syringe with her bare hands, opened the alcohol wipe and lifted up the resident's gown so that his abdomen was exposed. She wiped his abdomen with the alcohol pad with her bare hands and gave the injection. The LPN did not donn gloves during the entire procedure. The LPN then left the resident's room, placed her syringe in the sharps container on the side of the medication cart, and continued with the oral medication pass for the resident. The LPN did not wash her</p>		<p>is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was LPN #3 was educated by the Director of Nursing on appropriately donning gloves for resident care and for appropriate hand washing. LPN #2 was educated by the Director of Nursing on appropriate hand washing. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: There were no other residents affected by this practice. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur is: All staff has been in-serviced on the importance of hand washing, when to wash hands, and when to wear and not wear gloves by DON or designee 2/24 – 3/9.12. Staff from all departments are being reviewed by the Housekeeping supervisor and checked for proper hand washing technique utilizing the Black Light System. To ensure the deficient practice does not reoccur, the monitoring system established is A Performance Improvement indicator has been established which evaluates compliance with hand washing and when to wear gloves. The Infection control nurse or designee will complete audits 2 X/wk. of staff on all</p>				

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	<p>hands with soap or water or use alcohol gel prior to the injection or after the injection.</p> <p>Interview with LPN #3 on 2/15/12 at 9:06 a.m., indicated she was supposed to wear gloves when giving an injection and she should have washed her hands after administering the injection with soap and water or by using alcohol gel.</p> <p>2. On 2/15/12 at 11:00 a.m., LPN #2 was observed performing an accucheck for Resident #14. The LPN had washed her hands with soap and water and donned a clean pair of gloves. She then wiped the resident's finger with an alcohol swab and obtained a blood sample from him. She placed the sample on the strip and received the glucometer reading. She then removed her gloves and wiped down the glucometer with a disinfectant cloth with her bare hands. The LPN then walked out of the room and did not wash her hands with soap and water or use alcohol gel after removing her soiled gloves.</p> <p>Interview with LPN #2 on 2/15/12 at 11:14 a.m., indicated she was supposed to wash her hands with soap and water and/or use alcohol after glove removal and before leaving the resident's room.</p>		<p>shifts from all departments regarding hand washing after rendering care of service. Audits will be weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with result forwarded to the facility performance improvement committee for further evaluation or resolution for a minimum of six months</p>				

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	<p>Review of the undated but current Hand Hygiene policy provided by the Director of Nursing, indicated Handwashing should be completed when hands were visibly dirty, soiled with blood with blood or other body fluids.</p> <p>Review of the undated but current subcutaneous injection policy provided by the Director of Nursing indicated universal precautions or other infection control standards were to be followed such as hands should be washed before and after the procedure and gloves shall be worn when appropriate.</p> <p>Interview with the Director of Nursing on 2/20/12 at 10:14 a.m., indicated her expectations for staff was to wear gloves while giving any injections and proper handwashing with soap and water or alcohol gel should be done after glove removal and before leaving resident rooms.</p> <p>3.1-18(I)</p>				