

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2013
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NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for the Investigation of Complaint IN00135457.</p> <p>Complaint: IN00135457 Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F314, F364 and F441.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: September 11 & 12, 2013</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 8 SNF/NF: 88 Total: 96</p> <p>Census Payor Type: Medicare: 7 Medicaid: 77 Other: 12 Total: 96</p> <p>Sample: 8</p>	F000000	The creation and submission of this Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after September 27, 2013	

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>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on September 16, 2013.</p>			
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F000282 SS=D	<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 residents plans of care and physician orders were followed in that when residents were identified with pressure ulcers, excoriation and identified as a fall risk the nursing staff failed to ensure the implementation of physician orders and plans of care for 2 of 3 residents reviewed for pressure ulcers and 1 of 1 resident reviewed for fall risk in a sample of 8 residents. (Residents "F" and "E").</p> <p>Findings include:</p> <p>1. The record for Resident "F" was reviewed on 09-11-13 at 10:50 a.m. Diagnoses included, but were not limited to, hemiplegia, cerebral vascular accident, hypertension, after-care cranial, and muscle spasms. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set assessment, dated 09-02-13</p>	F000282	<p>F282 It is the practice of this provider to provide services by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident F:Residentreceives care as written in the care plan, c.n.a. assignment sheet, physician's orders, and has staff present during toilet use. Resident reviewed by the interdisciplinary team to ensure plan of careand c.n.a. assignment sheets are updated in accordance with physician orders including (but not limited to) wound tx, positioning,and fall precautions.Resident E: Resident receives care as written in the care plan, c.n.a. assignment sheet, and physician's orders.Resident reviewed by the interdisciplinary team to ensure plan of careand c.n.a. assignment sheets are updated in accordance with physician orders including (but not limited to) wound tx and positioning. How will you identify other residents having the potential to be affected by the same deficient practice and what</p>	09/27/2013			

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	<p>indicated the resident had no cognitive impairment and also indicated the resident required extensive assistance with transfer, bed mobility, toileting and hygiene. The assessment indicated the resident did not have a pressure ulcer.</p> <p>The resident's current plan of care, originally dated 06-13-13 indicated the resident had ADL (activities of daily living) Functional / Rehabilitation Potential. "Self care deficit related to decreased mobility, hx [history] of CVA [cerebral vascular accident] with hemi [hemiplegia], hemicraniectomy, insomnia."</p> <p>After the Initial tour of the facility, on 09-11-13 at 9:30 a.m., the Director of Nurses indicated the resident was recently assessed with a pressure ulcer.</p> <p>A review of physician orders, dated 08-27-13 instructed the nursing staff to apply calmoseptine to the buttocks qs (every shift) for redness.</p> <p>A subsequent physician order, dated 09-01-13 instructed the nursing staff to apply Calmoseptine to bilateral buttocks two times a day.</p>		<p>corrective action will be taken? All Residents with skin integrity and fall risk concerns have the potential to be affected by the alleged deficient practice. All residents with skin integrity and fall risk concerns have been reviewed by licensed nursing staff to ensure their plan of care and resident care sheets are in accordance with physician orders – including but not limited to, wound care, fall precautions, and positioning. Nursing staff will be re-educated on following Physician Orders and Resident Care Plan/Resident Care Sheets by September 27, 2013 by the DNS/designee. Nursing staff will also be re-educated on the Skin Management Policy, The Shower Report Policy, The Fall Management Program, Skin Checks, and Licensed Staff Resident Care Rounds Policy by September 27, 2013 by the DNS/Designee. DNS/designee reviews the physician orders and The Facility Activity Report in the Interdisciplinary Team Meeting to ensure the Plan of Care and Resident Care Sheets are updated accordingly. The Weekend Nurse Manager/designee will review orders to ensure Plan of Care and Resident Care Sheets are updated accordingly on the weekend/holidays. What measures will be put into place or what systemic changes you will make to ensure that the deficient</p>		

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	<p>A review of the resident "shower report," dated 08-28-13, 08-31-13 and 09-04-13 lacked indication of the resident wound. The "shower report," clearly prompts the CNA (certified nurse aide) to "circle problem area and check all boxes as needed."</p> <p>A subsequent plan of care, dated 09-05-13, indicated the condition of the resident's buttocks had declined and noted as "Problem - Resident has impaired skin integrity: Stage 3 [Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling] and Unstageable to left buttocks."</p> <p>A progress note, dated 09-06-13 at 10:54 a.m. indicated "wound rounds with NP [nurse practitioner] DNS [Director of Nursing Services], MDS [Minimum Data Set] and DM [Dietary Manager] at bedside. Resident followed weekly related to impaired skin integrity to left buttocks."</p> <p>"#1 left superior buttock: area is Unstageable and suspected DTI [deep tissue injury] with scant sero-sanguineous drainage, no odor</p>		<p>practice does not recur Physician orders are reviewed in Interdisciplinary Meeting and Resident Plan of Care and Resident Care Sheets are updated accordingly. Nursing staff will be re-educated on following Physician Orders and Resident Care Plan/Resident Care Sheets by September 27, 2013 by the DNS/designee. Nursing staff will also be re-educated on the Skin Management Policy, The Shower Report Policy, The Fall Management Program, Skin Checks, and Licensed Staff Resident Care Rounds Policy by September 27, 2013 by the DNS/Designee. The Weekend Nurse Manager/DNS designee will review orders to ensure Plan of Care and Resident Care Sheets are updated accordingly on the weekends and holidays. Charge Nurse will complete a licensed nurse rounds sheet at the each shift to ensure physician's orders, care plans, and c.n.a. assignment sheets are implemented as written. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A Resident Care Rounds CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter. If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI Committee</p>				

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	<p>noted. Periwound skin is normal, no s/s [signs or symptoms] of infection noted. NP recommends to change tx. [treatment] to left buttock to polysporin powder with calmoseptine."</p> <p>A review of the resident's clinical record, contained a progress note dated by the local wound care company, dated 09-06-13 which indicated the following:</p> <p>"Location: left buttocks, Severity: Stage 3 DTI. Duration 08-28-13. Context: wounds are a result of pressure. Complaints and symptoms: Patient complains of gastrointestinal: bowel incontinence, genitourinary: urinary incontinence, musculoskeletal: deformities, muscle weakness, neurological one sided weakness."</p> <p>"Wound #1 Left superior buttock is a suspected deep tissue injury pressure ulcer and has received a status of not healed. Measurements are 1.4 cm [centimeters] length by 1.2 cm depth with an area of 1.68 sq. [square] cm. There is a scant amount of sero-sanguineous drainage noted which has no odor. General notes: 60% DTI."</p>		for review and follow up. Compliance date: September 27, 2013				

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	<p>"Wound #2 left inferior buttocks is a stage 3 pressure ulcer and has received a status of not healed. Measurements are 1.2 cm length by 0.9 cm width by 0.1 cm depth with an area of 1.08 sq cm and a volume of 0.108 cubic cm. There is a small amount of serosanguineous drainage noted which has not odor."</p> <p>"Plan - wound #1 apply polysporin powder to affected area(s) followed by application of calmoseptine or equivalent to area(s) every shift and PRN [as needed], incontinence. Wound #2 left inferior buttocks - apply polysporin powder to affected area(s) followed by application of calmoseptine, or equivalent to area(s) every shift and PRN, incontinence."</p> <p>"Assist with turning every two hours."</p> <p>During an interview on 09-12-13 at 9:45 a.m. the resident indicated "I've been up in this chair [wheelchair] since about 6:30 a.m. I think I got those bedsore because they didn't turn me." When interviewed if the resident could turn self in bed, the resident responded "No." When interviewed if the resident had been changed, checked for incontinence or position had been changed since early this morning, the resident</p>						

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	<p>responded "no." Upon completion of this interview the resident was taken for therapy.</p> <p>An interview on 09-12-13 at 9:55 a.m., Certified Nurse Aide #8 indicated she had been assigned to the resident "this morning. I haven't had to do anything for [resident] she'll let me know if she needs to be changed."</p> <p>In addition the resident's Minimum Data Set assessment, further indicated the resident had no cognitive impairment and also indicated the resident required extensive assistance in regard to transfer and toileting, and the assistance of two staff members.</p> <p>The assessment indicated the resident's balance was "not steady and only unable to stabilize herself when moving from a seated to a standing position and moving on and off the toilet."</p> <p>The resident's current plan of care, originally dated 06-13-13, indicated the resident was "at risk for fall due to decreased mobility, dx. [diagnosis] of HTN [hypertension], osteoporosis, hx. [history] of falls, incontinent episodes, antidepressant medication use, left</p>						

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	<p>hemiplegia and status post bone flap replacement."</p> <p>Approaches to this plan of care indicated "Staff to be present during toilet use."</p> <p>During an observation on 09-12-13 at approximately 10:10 a.m., the resident's call light was illuminating and sounding in the hallway. The licensed nurse indicated she needed to check on the resident. The resident was observed seated on the toilet with a gait belt positioned around her waist - without any staff member in attendance. The licensed nurse attempted to stand the resident independently and then indicated the need for additional assistance.</p> <p>During an interview on 09-12-13 at 10:25 a.m., CNA (Certified Nurses Aide) #8 was observed walking down the hallway. The CNA verified the resident was part of her assignment and further indicated she had been on her 15 minute break.</p> <p>2. The record for Resident "E" was reviewed on 09-11-13 at 11:10 a.m. Diagnoses included, but were not limited to, diabetes mellitus, breast cancer, hypertension, depression and history of a fractured ankle. These</p>						

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	<p>diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS, dated 08-25-13 indicated the resident had no cognitive impairment, and required extensive assistance with two staff member for bed mobility, transfer, toileting and hygiene. The assessment indicated the resident was always incontinent of bowel and frequently incontinent of bladder and further indicated the resident did not have pressure ulcers.</p> <p>The resident's current plan of care, originally dated 07-09-13 indicated the resident required assistance with ADL's related to status post right ankle ORIF (open reduction and internal fixation), DVT's (deep vein thrombosis), GERD (gastroesophageal reflux disorder), HTN (hypertension), Depression, Breast CA (cancer) and DM (diabetes mellitus). Approaches to this plan of care included "assist with transfers as needed, incontinent care as needed, provide shower two times per week, partial bath in between."</p> <p>After the Initial tour of the facility, on 09-11-13 at 9:30 a.m., the Director of Nurses indicated the resident was</p>				

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	<p>recently assessed with a pressure ulcer.</p> <p>A progress note, dated 09-06-13 at 11:45 a.m., indicated the resident "followed weekly related to impaired skin integrity to left buttocks. Area appears as stage 3 pressure ulcer that is 100 % granulation with scant sero-sanguineous drainage and no odor noted. NP [nurse practitioner] recommends to d/c [discontinue] current tx. [treatment] and start Polysporin powder and calmoseptine every shift and prn."</p> <p>A review of the clinical record included a progress note from the local contracted wound care company and dated 09-06-13, which indicated the following:</p> <p>"Location: left buttocks. Severity: stage 3. Duration 09-02-13. Context: wound is a result of pressure. Modifying factors: fecal incontinence, urinary incontinence and debility. Needs assistance with repositioning, needs assistance with transfers. Complaints and symptoms: gastrointestinal: bowel incontinence, genitourinary: urinary incontinence, musculoskeletal: muscle weakness, neurological: weakness, psychiatric: depression."</p>						

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	<p>"Neurological: Diminished sensation in lower extremities."</p> <p>"Wound #1 left buttock is a Stage 3 pressure ulcer and has received a status of not healed. Measurements are 0.8 cm length by 0.7 cm width by 0.1 cm depth with an area of 0.56 sq cm and a volume of 0.056 cubic cm. There is a scant amount of sero-sanguineous drainage noted which has no odor. The wound margin is well defined."</p> <p>"Plan: wound #1 left buttocks - Calmoseptine - apply polysporin powder to affected area(s) followed by application of Calmoseptine or equivalent to area(s) every shift and PRN incontinence. Off loading: turn every two hours. Pressure ulcer stage 3 - diligent offloading. Full incontinence of feces - contain. Keep pt. [patient] clean and dry with wounds free from contamination. Functional urinary incontinence - same as above. Assist patient with turning and repositioning every two hours."</p> <p>A review of the resident "shower sheets," dated 09-03-13 and 09-07-13 indicated "circled" areas of concern on the residents perineum</p>			

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	<p>and lower buttocks, and the 09-10-13 shower report indicated the resident "refused a shower," but lacked identification of skin areas of concern. The shower report contained an area for the "charge nurse signature," and prompted the nurse "all skin problems must be assessed and documented by the charge nurse. Any shower refusal must be recorded with a second attempt tried."</p> <p>The resident's current plan of care, originally dated 09-05-13, indicated the "resident has impaired skin integrity: Stage 3 left buttocks." Interventions to this plan of care included "treatment as ordered, turn and reposition every two hours."</p> <p>During an interview on 09-11-13 at 2:00 p.m., the resident indicated "I've been in these briefs so long - I've been using them since I came here in June 2013. Once I got up yesterday around 11:00 a.m., I stayed up in this chair until 5:00 p.m. The other day I got up around 11:00 a.m. and stayed up until 9:00 p.m. I don't wet much so they don't have to do too much for me."</p> <p>During an observation on 09-12-13 at 8:15 a.m., the resident was observed seated in bed with the head of the</p>			

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	<p>bed elevated and her breakfast tray positioned on the over bed table. The resident remained seated upright in bed until 10:45 a.m., at which time a skin assessment was requested. The resident, with the assistance of the CNA #8, was turned to the right side. The resident had indentations present across bilateral hips and spanned across her buttocks.</p> <p>This Federal tag relates to Complaint IN00135457.</p> <p>3.1-35(g)(2)</p>			

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview the facility failed to ensure residents did not acquire pressure ulcers, in that when dependent residents entered the facility without a pressure ulcer, acquired pressure ulcers which progressed in size and to Stage 3 and unstageable ulcers and required additional interventions by a contracted wound specialist to aide in the resolution of the area. This deficient practice effected 2 of 3 residents reviewed with pressure ulcers in a sample of 6. (Residents "F" and "E").</p> <p>Findings include:</p> <p>1. The record for Resident "F" was reviewed on 09-11-13 at 10:50 a.m. Diagnoses included, but were not limited to, hemiplegia, cerebral</p>	F000314	F 314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES It is the practice of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident F: Is receiving care and services as written in the care plan, physician's orders and c.n.a. assignment sheet. New Skin review completed. Care plan and Resident Care Sheet has been updated for preventative measures in accordance with physician orders. Resident E: Is receiving care and services as	09/27/2013			

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	<p>vascular accident, hypertension, after-care cranial, and muscle spasms. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set assessment, dated 09-02-13, indicated the resident had no cognitive impairment and also indicated the resident required extensive assistance with transfer, bed mobility, toileting and hygiene. The assessment indicated the resident did not have a pressure ulcer.</p> <p>The resident's current plan of care, originally dated 06-13-13 indicated the resident had ADL (activities of daily living) Functional / Rehabilitation Potential. "Self care deficit related to decreased mobility, hx [history] of CVA [cerebral vascular accident] with hemi [hemiplegia], hemicraniectomy, insomnia."</p> <p>After the Initial tour of the facility, on 09-11-13 at 9:30 a.m., the Director of Nurses indicated the resident was recently assessed with a pressure ulcer.</p> <p>A review of physician orders, dated 08-27-13 instructed the nursing staff</p>		<p>written in the care plan, physician's orders and c.n.a assignment sheet. New Skin review completed. Care plan and Resident Care Sheet has been updated for preventative measures in accordance with physician orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with Skin Integrity concerns have the potential to be effected by the alleged deficient practice Facility skin sweep will be conducted by September 27, 2013 by Nurse Management Team to ensure all interventions are in place to promote healing per physician's order, skin prevention interventions are ordered, all skin conditions are identified, and physician is notified and plan of care is updated and followed. Physician orders are reviewed in Interdisciplinary Meeting and Resident Plan of Care and Resident Care Sheets are updated accordingly. The Weekend Nurse Manager/DNS designee will review orders to ensure Plan of Care and Resident Care Sheets are updated accordingly on the weekends and holidays. Nursing staff will be in-serviced on Skin Management Program, Shower Report Policy, License Staff Care rounds Policy, and Skin Checks by the Director of Nursing Services/Designee</p>		

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	<p>to apply calmoseptine to the buttocks qs (every shift) for redness.</p> <p>A subsequent physician order, dated 09-01-13 instructed the nursing staff to apply Calmoseptine to bilateral buttocks two times a day.</p> <p>A review of the resident "shower sheets," dated 08-28-13, 08-31-13 and 09-04-13 lacked indication the resident's wound had declined. The "shower report," clearly prompts the CNA (certified nurse aide) to "circle problem area and check all boxes as needed."</p> <p>A subsequent plan of care, dated 09-05-13 indicated the condition of the resident's buttocks had declined and noted as "Problem - Resident has impaired skin integrity: Stage 3 [Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling] and Unstageable to left buttocks."</p> <p>A progress note, dated 09-06-13 at 10:54 a.m. indicated "wound rounds with NP [nurse practitioner], DNS [Director of Nursing Services], MDS</p>		<p>designee by September 27, 2013 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nursing staff will be in-serviced on Skin Management Program, Shower Report Policy, License Staff Care rounds Policy, and Skin Checks by the Director of Nursing Services/Designee designee by September 27, 2013Skin sweeps will be conducted by Nurse Management Team twice a month.All residents will have a skin assessment completed weekly by the charge nurse. Shower reports and nurse skin assessment to be reviewed by Unit Manger daily.Nurse consultant to provide additional education to nurse management team on skin management program and prevention.Charge Nurse will complete a licensed nurse rounds sheet at the each shift to ensure that physician's orders, care plan and c.n.a assignment sheet are implemented as written and preventative skin measures are in place and followed.Medical Records Director or designee will complete a weekly audit to ensure that skin assessments have been completed per schedule. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Skin Management</p>				

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	<p>[Minimum Data Set] and DM [Dietary Manager] at bedside. Resident followed weekly related to impaired skin integrity to left buttocks. #1 left superior buttock: area is Unstageable and suspected DTI [deep tissue injury] with scant sero-sanguineous drainage, no odor noted. Periwound skin is normal, no s/s [signs or symptoms] of infection noted. NP recommends to change tx. [treatment] to left buttock to polysporin powder with calmoseptine.</p> <p>A review of the resident's clinical record, contained a progress note dated by the local wound care company, dated 09-06-13 which indicated the following: "Location: left buttocks, Severity: Stage 3 DTI. Duration 08-28-13. Context: wounds are a result of pressure. Complaints and symptoms: Patient complains of gastrointestinal: bowel incontinence, genitourinary: urinary incontinence, musculoskeletal: deformities, muscle weakness, neurological one sided weakness."</p> <p>"Wound #1 Left superior buttock is a suspected deep tissue injury pressure ulcer and has received a status of not healed. Measurements are 1.4 cm [centimeters] length by 1.2 cm depth</p>		<p>Program CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</p>		

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	<p>with an area of 1.68 sq. [square] cm. There is a scant amount of sero-sanguineous drainage noted which has no odor. General notes: 60% DTI."</p> <p>"Wound #2 left inferior buttocks is a stage 3 pressure ulcer and has received a status of not healed. Measurements are 1.2 cm length by 0.9 cm width by 0.1 cm depth with an area of 1.08 sq cm and a volume of 0.108 cubic cm. There is a small amount of serosanguineous drainage noted which has no odor."</p> <p>"Plan - wound #1 apply polysporin powder to affected area(s) followed by application of calmoseptine or equivalent to area(s) every shift and PRN [as needed], incontinence. Wound #2 left inferior buttocks - apply polysporin powder to affected area(s) followed by application of calmoseptine, or equivalent to area(s) every shift and PRN, incontinence."</p> <p>"Assist with turning every two hours."</p> <p>During an interview on 09-12-13 at 9:45 a.m. the resident indicated "I've been up in this chair [wheelchair] since about 6:30 a.m. I think I got those bedsores because they didn't turn me." When interviewed if the</p>			

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	<p>resident could turn self in bed, the resident responded "No." When interviewed if the resident had been changed, checked for incontinence or position had been changed since early this morning, the resident responded "no." Upon completion of this interview the resident was taken for therapy.</p> <p>An interview on 09-12-13 at 9:55 a.m., Certified Nurse Aide #8 indicated she had been assigned to the resident "this morning. I haven't had to do anything for [resident] she'll let me know if she needs to be changed."</p> <p>2. The record for Resident "E" was reviewed on 09-11-13 at 11:10 a.m. Diagnoses included, but were not limited to, diabetes mellitus, breast cancer, hypertension, depression and history of a fractured ankle. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS, dated 08-25-13 indicated the resident had no cognitive impairment, and required extensive assistance with two staff member for bed mobility, transfer, toileting and hygiene. The assessment indicated the resident was always incontinent of bowel and</p>						

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	<p>frequently incontinent of bladder and further indicated the resident did not have pressure ulcers.</p> <p>The resident's current plan of care, originally dated 07-09-13 indicated the resident required assistance with ADL's related to status post right ankle ORIF (open reduction and internal fixation), DVT's (deep vein thrombosis), GERD (gastroesophageal reflux disorder), HTN (hypertension), Depression, Breast CA (cancer) and DM (diabetes mellitus). Approaches to this plan of care included "assist with transfers as needed, incontinent care as needed, provide shower two times per week, partial bath in between."</p> <p>After the Initial tour of the facility, on 09-11-13 at 9:30 a.m., the Director of Nurses indicated the resident was recently assessed with a pressure ulcer.</p> <p>A progress note, dated 09-06-13 at 11:45 a.m., indicated the resident "followed weekly related to impaired skin integrity to left buttocks. Area appears as stage 3 pressure ulcer that is 100 % granulation with scant sero-sanguineous drainage and no odor noted. NP [nurse practitioner]</p>			

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	<p>recommends to d/c [discontinue] current tx. [treatment] and start Polysporin powder and calmoseptine every shift and prn."</p> <p>A review of the clinical record included a progress note from the local contracted wound care company and dated 09-06-13, which indicated the following:</p> <p>"Location: left buttocks. Severity: stage 3. Duration 09-02-13. Context: wound is a result of pressure. Modifying factors: fecal incontinence, urinary incontinence and debility. Needs assistance with repositioning, needs assistance with transfers. Complaints and symptoms: gastrointestinal: bowel incontinence, genitourinary: urinary incontinence, musculoskeletal: muscle weakness, neurological: weakness, psychiatric: depression."</p> <p>"Neurological: Diminished sensation in lower extremities."</p> <p>"Wound #1 left buttock is a Stage 3 pressure ulcer and has received a status of not healed. Measurements are 0.8 cm length by 0.7 cm width by 0.1 cm depth with an area of 0.56 sq cm and a volume of 0.056 cubic cm. There is a scant amount of</p>			

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	<p>sero-sanguineous drainage noted which has no odor. The wound margin is well defined."</p> <p>"Plan: wound #1 left buttocks - Calmoseptine - apply polysporin powder to affected area(s) followed by application of Calmoseptine or equivalent to area(s) every shift and PRN incontinence. Off loading: turn every two hours. Pressure ulcer stage 3 - diligent offloading. Full incontinence of feces - contain. Keep pt. [patient] clean and dry with wounds free from contamination. Functional urinary incontinence - same as above. Assist patient with turning and repositioning every two hours."</p> <p>A review of the resident "shower sheets," dated 09-03-13 and 09-07-13 indicated "circled" areas of concern on the residents perineum and lower buttocks, and the 09-10-13 shower report indicated the resident "refused a shower," but lacked identification of skin areas of concern. The shower report contained an area for the "charge nurse signature," and prompted the nurse "all skin problems must be assessed and documented by the charge nurse. Any shower refusal must be recorded with a second attempt tried."</p>			

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	<p>The resident's current plan of care, originally dated 09-05-13, indicated the "resident has impaired skin integrity: Stage 3 left buttocks." Interventions to this plan of care included "treatment as ordered, turn and reposition every two hours."</p> <p>During an interview on 09-11-13 at 2:00 p.m., the resident indicated "I've been in these briefs so long - I've been using them since I came here in June 2013. Once I got up yesterday around 11:00 a.m., I stayed up in this chair until 5:00 p.m. The other day I got up around 11:00 a.m., and stayed up until 9:00 p.m. I don't wet much so they don't have to do too much for me."</p> <p>During an observation on 09-12-13 at 8:15 a.m., the resident was observed seated in bed with the head of the bed elevated and her breakfast tray positioned on the over bed table. The resident remained seated upright in bed until 10:45 a.m., at which time a skin assessment was requested. The resident, with the assistance of the CNA #8, was turned to the right side. The resident had indentations present across bilateral hips and spanned across her buttocks.</p>			

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	<p>This Federal tag relates to Complaint IN00135457.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000323 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. Based on observation, record review and interview the facility failed to ensure the supervision of a dependent resident, in that when a resident was identified as a fall risk, the resident was left unattended on the commode for 1 of 1 resident reviewed for the potential for falls in a sample of 8. (Resident "F").</p> <p>Findings include:</p> <p>1. The record for Resident "F" was reviewed on 09-11-13 at 10:50 a.m. Diagnoses included, but were not limited to, hemiplegia, cerebral vascular accident, hypertension, after-care cranial, and muscle spasms. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set assessment, dated 09-02-13, indicated the resident had no cognitive impairment and also indicated the resident required extensive assistance in regard to</p>	F000323	F323It is the practice of this facility to 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident F has staff present during toilet use and care is provided per plan of care, c.n.a. assignment sheet and physician's orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected by the alleged deficient practice.C.N.A. #8 is no longer employed at facility.All fall risk residents physician orders have been reviewed and their Plan of Care and Resident Care Sheets updated accordingly to include fall precautions.Nursing Staff have been re-educated on the Fall Management Program Policy and Licensed Nurse Resident Rounds sheets by September 27, 2013 by	09/27/2013	

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	<p>transfer and toileting, and assistance of two staff members.</p> <p>In addition the assessment indicated the resident's balance was "not steady and only unable to stabilize herself when moving from a seated to a standing position and moving on and off the toilet."</p> <p>The resident's plan of care, originally dated 06-13-13, indicated the resident was "at risk for fall due to decreased mobility, dx. [diagnosis] of HTN [hypertension], osteoporosis, hx. [history] of falls, incontinent episodes, antidepressant medication use, left hemiplegia and status post bone flap replacement."</p> <p>Approaches to this plan of care indicated "Staff to be present during toilet use."</p> <p>During an observation on 09-12-13 at approximately 10:10 a.m., the resident's call light was illuminating and sounding in the hallway. The licensed nurse indicated she needed to check on the resident. The resident was observed seated on the toilet with a gait belt positioned around her waist - without any staff member in attendance. The licensed nurse attempted to stand the resident</p>		<p>DNS/designee.The Facility Activity report, including falls, and physician orders are reviewed in the interdisciplinary team meeting to ensure services are provided per physician's orders and plan of care and care plans are updated.The Charge Nurse/Weekend Nurse Manager reviews the physician orders andThe Facility Activity Report to ensure that services are provided per plan of care on theweekends/holidays. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nursing Staff have been re-educated on the Fall Management Program Policy and Licensed Nurse Resident Rounds sheets by September 27, 2013 by DNS/designee.The Charge Nurse reviews falls to ensure the physician orders are implemented and the Plan of Care is updated on theweekends.The IDT will review the physician orders at the clinical meeting.The IDT determines if further interventions or changes to the plan of care is necessary.Nurse rounds checklist will be completed by the charge nurses every shift to ensure care is provided per physician's orders, plan of care, and resident care/ CNA assignment sheets.Customer care representatives or manager on duty will make observations during rounds daily to ensure that</p>		

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	<p>independently and then indicated the need for additional assistance.</p> <p>During an interview on 09-12-13 at 10:25 a.m., CNA (Certified Nurses Aide) #8 was observed walking down the hallway. The CNA verified the resident was part of her assignment and further indicated she had been on her 15 minute break.</p> <p>3.1-45(a)(2)</p>		<p>the resident environment remains free of accident hazards, each resident receives adequate supervision and assistance devices to prevent accidents. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? An Resident Care Rounds CQI will be utilized weekly x 4, and monthly x6, quarterly thereafter. The CQI Committee will review the data collected. If a 95% threshold is not achieved, an action plan will be developed. Compliance Date: September 27, 2013</p>		

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview the facility failed to ensure resident's received food that was attractive and at the proper temperature for 2 of 2 observations. This deficient practice had the potential to effect 88 of 88 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 09-11-13 at 8:40 a.m., and with the Director of Nurses in attendance, resident "C" was observed seated in bed with the overbed table adjacent to her. When interviewed about the breakfast meal, the resident indicated the "eggs were cold." During this observation, although the resident had received a "room tray," she had received her breakfast on a plate but without a heating pallet to keep the food warm during service.</p> <p>Further observation, Resident "G" was also observed with her breakfast tray situated on the overbed table, and without a pallet to keep the food</p>	F000364	F364It is the practice of this facility to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C: Receives food at proper temperature and receives a warming pellet if food is to be warm. Resident G: Receives food at proper temperature and receives a warming pellet if food is to be warm. Resident H: receives food and beverages that are palatable, attractive, and at the proper temperature. Test trays will be monitored daily utilizing the Temperature Monitor Form. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice Dietary staff will be re- educated on Food Preparation Policy, Temperature	09/27/2013	

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	<p>warm during service. The Director of Nurses checked the food cart, and multiple resident trays were observed without the needed pallet.</p> <p>During an interview on 09-11-13 at approximately 9:00 a.m., the morning cook #5 indicated the pallets had not been used because the other kitchen staff member had not arrived to work in order to help with the meal service.</p> <p>Interview on 09-11-13 at 9:10 a.m., the Dietary Manager indicated that the pallets were to be used for all room trays and meals. "It does not matter if there is only 1 person here. I think that sometimes they stack a few at a time - which they are not suppose to do - they should be taking one pallet and a plate at a time."</p> <p>During an observation on 09-11-13 at 11:45 a.m., the food service for the meal meal was observed. At the kitchen service window were four trays already set up with the pallets and plates placed on each pallet. Each tray also contained a bowl of sherbet.</p> <p>In addition seven additional trays had been pre-set with pallets, plates and sherbet over the steam table.</p>		<p>Policy, and Hard Water Stain removal by September 27, 2013 by the Dietary Service Manager .Nursing staffwill be re-educated on Delivery and Documentation of Meal Service Policy by DNS/Designee by September 27, 2013.An additional Water Softner was installed and attached directly to the kitchen.Dietary staff to monitor meal service to ensure proper temperatures by obtaining and recording food temperatures prior to food delivery.Concerns to be resolved upon identification and reported to manager for further follow-up. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Dietary staff will be re-educated onFood Preparation Policy, Temperature Policy, and Hard Water Stain removal by September 27, 2013 by the Dietary Service Manager .Nursing staffwill be re-educated on Delivery and Documentation of Meal Service Policy by DNS/Designee by September 27, 2013.Maintenance to monitor salt in Water Softner in accordance with Preventive Maintenance Program. Dietary staff to monitor meal service to ensure proper temperatures by obtaining and recording food temperatures prior to food delivery.Concerns to be resolved upon identification and reported to manager for further follow-up.Staff who are noncompliant may be</p>				

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	<p>The dietary staff began loading the food cart for the dementia unit at 11:51 a.m. and the cart was taken to the secured unit.</p> <p>The cart arrived at the unit and the first tray was provided to a resident at 12:07 p.m. During this observation, the sherbet had melted and the consistency appeared as a thickened soup like liquid and a small amount of a firm center. The facility staff continued to serve the residents the sherbet, and the dietary manager, who was in attendance, did not intervene to replace the sherbet.</p> <p>During an interview on 09-11-13 at 1:00 p.m., resident "H" approached and handed a plastic glass of what appeared to be milk. The resident indicated, "I grew up on a farm and we had a lot of buttermilk and now I don't like it. Could you send this to the lab at the Board of Health to have it checked ?" The resident held up the plastic glass and swirled the milk around. The milk coated the inside of the the glass and as the liquid moved down the inside of the glass the milk appeared thick. The glass had a build of what appeared to be hard water stain.</p> <p>The regional dietician was notified by</p>		<p>re-educated and /or receive disciplinary action up to and including termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Meal Obersavation CQI to be completed by Dietary Services Manager/Designee 5x/week x 4 weeks and weekly x 4 weeks, monthly x 2, then quarterly.Short Sanitation check for lime deposit 3x/week .If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance Compliance date: September 27, 2013</p>				

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	<p>the facility staff of the concerns and she indicated on 09-12-13 at 8:15 a.m., she would check the water softener to see if it was functioning.</p> <p>During interview on 09-12-13 at 10:00 a.m., the Administrator indicated that although there was salt in the water softener tank, there was a problem with the water softener and the technician had been called.</p> <p>This Federal tag relates to Complaint IN00135457.</p> <p>3.1-21(a)(2)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <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 and record review the facility failed to ensure</p>	F000441	F441It is the practice of this facility to establish and maintain	09/27/2013			

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	<p>effective infection control preventative measures, in that when a resident had been identified with the infection Methicillin Resistant Staphylococcus Aureus, the nursing staff failed to implement precautions to alert other staff and visitors of the risk of infection for 1 of 1 residents with infection. (Resident "A")</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 09-11-13 at 1:30 p.m. Diagnoses included, but were not limited to, dementia - Alzheimer's, hypertension, aphasia, dysphasia, psychoses, diabetes mellitus and respiratory failure. In addition the resident had a tracheostomy, a gastrostomy feeding tube and an indwelling catheter. These diagnoses remained current at the time of the record review.</p> <p>During the initial tour of the facility on 09-11-13 at 8:30 a.m., and with the Director of Nurses in attendance, the resident was observed laying in bed and slightly turned to the left side. During this observation, the Director of Nurses indicated the resident was currently on Hospice. The resident shared the room with Resident "D."</p>		<p>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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A: Contact precautions were discontinued per physician's order on 9-23-13. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with a communicable disease are at risk of this alleged deficient practice. All residents with diagnosis' and/or symptoms that require transmission based precautions will be reviewed to ensure that all proper precautions are in place. Any roommate of a resident who is identified as needing transmission based precautions will be reviewed by the Director of Nursing Services or designee for appropriate isolation precautions. Nursing staff will be re-educated on Transmission Based Precaution Guidelines and Methicillin-Resistant Staphylococcus Aureus by September 27, 2013 by the Director of Nursing Services/Designee to monitor for compliance. Licensed Nursing to complete Resident Care Round</p>	

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	<p>A review of the resident's clinical record contained a nurses progress noted dated, 08-26-13 at 11:36 a.m. "Gastrostomy [feeding] tube has yellow discharge secreting from around the site. MD [Medical Doctor] office made aware via fax [facsimile] and phone, awaiting response."</p> <p>A subsequent notation, dated 08-27-13 at 10:27 a.m., indicated "Swab obtained for GT [gastrostomy tube] at this time. Lab informed to pick up specimen."</p> <p>A progress note, dated 08-29-13, indicated "Culture results received GT site obtained. Results called to MD, new order received and implemented for antibiotic and new treatment for GT site. Pharmacy and family notified of order."</p> <p>The laboratory results indicated the resident had "Methicillin Resistant Staphylococcus Aureus Heavy Growth *** Staph Aureus is MRSA *** "</p> <p>Further review of the physician orders, dated 08-29-13 instructed the nursing staff to administer Bactrim DS (an antibiotic) times 10 days, Cleanse g-tube site with betadine - wash times 10 days, continued current treatment</p>		<p>sheets every shift to ensure Infection Control precaution and protective personal equipment is in place. What measures will be put intoplace or what systemic changes you will make to ensure that the deficient practice does not recur? Interdisciplinary team review (during daily (Monday-Friday) AM meeting) and charge nurse on the weekends will review physician orders and update Care Plans and Resident Care Sheets accordingly to include Isolation Precautions as needed.Any roommate of a resident who is identified as needing transmission based precautions will be reviewed by the Director of Nursing Services or designee for appropriate isolation precautions.Licensed Nursing to complete Resident Care Round sheets every shift to ensure that Infection Control precaution and protective personal equipment is in place.Nursing staff will be re-educated on Transmission Based Precaution Guidelines and Methicillin-Resistant Staphylococcus Aureus by September 27, 2013 by the Director of Nursing Services/Designee to monitor for compliance.A Nurse rounds sheet will be completed each shift by charge nurses to ensure proper infection control precautions are in place. How the corrective action (s)will be monitored to ensure thedeficient practice will</p>		

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	<p>to site, reswab g-tube site in 2 weeks, no isolation per MD."</p> <p>A review of the facility policy on 09-12-13 at 8:10 a.m., and dated as "reviewed on 10/2011," and titled, "METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)," indicated the following:</p> <p>"Policy: The facility shall utilize proper infection control and prevention when dealing with resident(s) with Methicillin Resistant Staphylococcus Aureus."</p> <p>"Purpose: To prevent the spread of infections caused by Methicillin Resistant Staphylococcus Aureus (MRSA)."</p> <p>"Procedure:... d. Resident Placement - infected residents should be placed in a private room or cohorted. If neither is available a semi private room with a low risk roommate is acceptable. e. Place sign indicated "See Nurse" on doorway. f. Personal Protective Equipment (PPE) should be placed in the resident room in a designated three drawer storage unit. i. Gloves and hand hygiene - Gloves should be put on before or immediately upon entry to room. Gloves should be changed after on</p>		<p>not recur, i.e., what quality assurance program will be put into place? A Infection Control CQI tool will be utilized weekly x 4, monthly x 2, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% a threshold is not achieved, an action plan will be developed. Completion Date: September 27, 2013</p>				

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	<p>[sic] contact with infectious matter, moving from a contaminated body site to a clean body site or if become torn. Remove gloves and wash hands before leaving resident's room or performing care to another resident. After removing gloves and washing hands ensure hands do not touch potentially contaminated surfaces or items in the resident's room. ii. Gowns - Gown should be put on before or immediately upon entry to the room/cubicle. Gloves should be used with gown. Gown should be used for any contact with resident or contaminated areas / surfaces. Upon completion of tasks remove and discard gloves before removing gown. Remove and discard gown, then wash hands prior to leaving room. Ensure that clothing does not contact potentially contaminated environmental surfaces."</p> <p>A review of the facility policy on 09-12-13 at 9:30 a.m., titled "TRANSMISSION BASED PRECAUTION GUIDELINES," and dated as reviewed 10/2011 and 05/2012, indicated the following clarification in regards to infections.</p> <p>"Policy" The facility shall utilize the appropriate infection control</p>			

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	<p>precaution guidelines based on the identified concerns or issues."</p> <p>"Purpose: To maintain and institute the appropriate precautions to prevent the spread of infection."</p> <p>"Key Terms: Cohort: refers to the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. Contact Precautions: refers to measure that are intended to prevent transmission of infectious agents either by direct or indirect contact with the residents or the resident's environment. Personal Protective Equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury."</p> <p>"Specific Organism Recommendations - organism Clostridium Difficile - contact precautions."</p> <p>During a subsequent observation on 09-11-13 at 2:00 p.m., the resident was positioned on the right side. With the Director of Nurses and Licensed Nurse #9 in attendance, a body assessment was conducted. During</p>						

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	<p>this observation, the resident's door lacked signage to alert visitors or other staff members to "report to the nurse," and a three drawer storage unit to contain personal protective equipment had not been placed in the room, and the body assessment was conducted by both nurses without the use of a gown.</p> <p>An observation on 09-12-13 at 8:30 a.m., the door to the resident room continued to lack the needed signage, or the three drawer storage unit to contain personal protective equipment as outlined in the facility policy.</p> <p>From the time the resident was identified with MRSA (08-29-13) thru the observation on 09-12-13, 15 days, the facility policy was not followed in regard to contact isolation and the precautions needed to prevent the spread of infection.</p> <p>This Federal tag relates to Complaint IN00135457.</p> <p>3.1-18(b)(2)</p>				