

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2011
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN46755
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 12-15, 2011</p> <p>Facility number: 000402 Provider number: 155392 AIM number: 100288120</p> <p>Survey team: Honey Kuhn, RN, TC Carol Miller, RN Shelly Miller-Vice, RN</p> <p>Census bed type: SNF/NF: 22 Total: 22</p> <p>Census payor type: Medicaid: 20 Other: 2 Total: 22</p> <p>Sample: 10 Supplemental sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 22, 2011 by Bev Faulkner, RN</p>	F0000	<p>January 9, 2012 Ms. Brenda Meredith, Area Supervisor Division of Long Term Care INDIANA STATE DEPARTMENT OF HEALTH 2 North Meridian Street, Section 4-B Indianapolis, Indiana 46204-3006 RE: <b>Hickory Creek at Kendallville</b></p> <p><b>Provider No: 15-5392</b></p> <p><b>Recertification and State Licensure Survey</b> Dear Ms. Meredith: Attached for your review and anticipated approval, you will find the completed form CMS - 2567L Statement of Deficiencies and Plan of Correction for the recent Recertification and State Licensure Survey conducted on December 15, 2011 , at Hickory Creek at Kendallville; Kendallville, Indiana. Please be advised that it is our intent to have this plan of correction also serve as our Allegation of Compliance. Compliance is effective on January 14, 2012. Should you have questions regarding the attached Plan of Correction / Allegation of Compliance, then please do not hesitate to contact me. Sincerely, Laura Etter Administrator</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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F0246 SS=E	<p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interviews and observations, the facility failed to ensure toileting facilities located in the facility hallways were available for 5 of 8 interviewable residents. This deficiency had the potential to effect 19 of 22 in the resident population of 22 residents identified as utilizing the toileting facilities in the 36 bed facility. (Residents #2, #15, #16, #21, and #22).</p> <p>Findings include:</p> <p>During the initial tour, on 12/12/11 between 7:00 a.m. and 7:30 a.m., LPN #2 indicated the facility had one resident room with a toilet, sink, and shower. All other resident rooms contained only handwashing sinks.</p> <p>On observation, the facility consisted of 4 hallways making a large outer square containing the resident rooms. The facility had 3 toilet/sink/showering areas located on 3 of the 4 corners of the inner square of the facility. Nineteen of the 22 residents were identified as utilizing the 3</p>	F0246	<p>F246 Reasonable Accommodation of Needs/Preferences</p> <p>It is the standard and policy of this facility that each resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, including making sure that toileting facilities are available to meet the resident's needs.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Residents #16 and #21 no longer reside in the facility. The Director of Nursing will meet with residents #2, #15, and #22 to discuss toileting concerns and possible solutions. Issues and concerns will be followed up on immediately.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>The Director of Nursing and MDS Coordinator will review the bowel and bladder assessments of all</p>	01/14/2012	

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	<p>toilet/sink/showering areas.</p> <p>Interviews were held throughout the survey with eight residents identified as interviewable by LPN #2 during the initial tour. During interviews, 5 of the 8 indicated they had to wait for periods of time to use the toilet facilities.</p> <p>During the group interview, on 12/13/11 at 1:00 p.m., residents indicated the following:</p> <p>Resident #22 indicated she had been incontinent 4 or 5 times since November due to waiting for access to the toilet area. Resident #22 indicated she also had been in toilet area and had a CNA ask her to hurry up so another resident could be showered.</p> <p>Resident #2 indicated being incontinent at least 2 or 3 times in the previous 6 weeks while awaiting the toilet facilities.</p> <p>Resident #15 indicated being incontinent because of waiting to use the toilet facilities.</p> <p>Resident #16, during interview on 12/14/11 at 2:00 p.m., indicated having to wait to use the toilet facilities. Resident #16 indicated being able to ambulate without assistance and would go around</p>		<p>residents residing in the facility. Resident care plans will be updated to correspond with specific toileting needs. In addition, toileting information will be updated on the C.N.A. assignment sheets as needed.</p> <p>In the future, if the DON or MDS Coordinator identifies a resident whose toileting needs are not being met appropriately, she will make sure that the resident's bowel and bladder needs are reassessed at that time. Once that is done, the information will be updated on the C.N.A. assignment sheet, and any changes will be noted on the 24 hour sheet for communication to other shifts. Once the resident is taken care of, the DON will meet with the nursing staff involved and will re-inservice them on facility's policy and procedure regarding accommodation of the resident's bathroom needs. She will also render progressive discipline for continuing compliance issues.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>On January 5, 2012 the Administrator and Director of Nursing will present an inservice to nursing staff addressing toileting concerns. C.N.A. assignment sheets will be updated to include specific toileting needs of each resident. Ensuring toilets are clean and ready</p>		

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	<p>the hallway to find an accessible toilet facility.</p> <p>Resident #21, during interview on 12/15/11 at 8:30 a.m., indicated there was almost always a wait to utilize the toileting facilities.</p> <p>All 5 residents indicated the toilet facilities, many times, had to be cleaned by staff prior to usage by the residents.</p> <p>Interview with CNA #7 on 12/14/11 at 10:00 a.m., indicated staff were to clean the toilet facilities after assisting residents back to their rooms.</p> <p>3.1-3(v)(1)</p>		<p>for use is a task that will be placed on the C.N.A. assignment sheets. At the end of each shift, C.N.A. assignment sheets will be passed on to the Director of Nursing for review to ensure task completion.</p> <p>In addition to the routine frequent rounds by the Director of Nursing and Administrator during each tour of duty, The Director of Nursing or designee will complete documented facility rounds at least 5 times a week for 30 days, 3 times a week for 30 days and then weekly for 30 days. Concerns identified during these rounds through observation or interview with residents will be addressed with the employee(s) who failed to meet the resident's needs or to follow facility policy as indicated in question #2.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u></p> <p>The DON will forward the results of these facility rounds to the Administrator and interdisciplinary team at the next scheduled morning management meeting which will occur at least 5 days a week for discussion and corrective action, if necessary. In addition, these results will also be forwarded to the Administrator and QA committee for further review at the monthly committee meeting. The QA committee members will review and</p>		

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F0248 SS=D	<p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observations, record reviews, and interviews, the facility failed to provide for activity needs correlating to care planned activities of 1 of 1 sampled resident's (# 12) who relied upon staff for activity needs in the sample of 10. Resident #12 was not provided activities for 2 of 4 days during the survey process.</p> <p>Findings include:</p> <p>On 12/12/2011 at 9:30 a.m., Resident #12 was observed during transfer to assess skin condition. Resident #12 was lying in bed in her room on a pressure relieving mattress, surrounded by gel filled soft barriers for positioning purpose. The resident was alert with her eyes open and tracking the activities of the staff. CNA</p>	F0248	<p>provide recommendations for continued process improvement. The committee may decide to stop the documented rounds when 100% compliance is achieved; however, rounds will be done by the Administrator and Don on an ongoing basis as part of their routine during each tour of duty.</p> <p><u>Date of Compliance: January 14, 2012</u></p> <p>F 248 Activities Meet Interests/Needs of Each Resident It is the standard and practice of this facility to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident, including provision of activities correlating to those provided in the resident's care plan. <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> The Activity Director received consultation and inservice education from Lacy Beyl consultant on January 3, 2012, regarding programming and care plan development for residents with special needs. Resident #12 has been reassessed and has received a physician's order</p>	01/14/2012

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	<p>#5 indicated Resident #12 does not get up more than "2 hours a day" because her tube feeding makes it unable for her to be transported outside of her room. LPN #2 inquired " ... did she (Resident #12) watch you with her eyes?... that's how she communicates, she really does know what's going on"</p> <p>At this time, 8 clear ornamental wind chime ornaments were observed suspended by a string from the ceiling over the head of Resident #12's bed area. The ornaments were approximately 5 feet from Resident #12's eyesight. The ornaments were not moving. There was no sound being produced by their dangling.</p> <p>On 12/12/2011 at 9:35 a.m., Resident #12 was taken in a specialized reclining wheelchair to the group activities in the dining room area at the front of the building. The activity was a staff reading current events from the newspaper.</p> <p>On 12/12/2011 at 11:50 a.m., Resident #12 was observed in her room, in her bed. The head of bed was elevated to approximately 30 degrees and the tube feeding was reconnected and running at the prescribed rate of administration per tube feeding pump. The television located at foot of the resident's bed,</p>		<p>to increase her activity to being up in a chair as tolerated. The Activity Director has updated Resident #12's care plan and assessment to identify her interests &amp; needs related to activity programs. In addition, the Activity Director will update the staff to inform them of the change in Resident #12's activities so that they can prepare her for attendance when they are scheduled.</p> <p>The Activity Director will receive ongoing consultation from Lacy Beyl consultant regarding all aspects of her job, including provision of activities that meet the needs and interests of all residents.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>The Activity Director will review the activity assessments, care plans, and participation records for all the residents in the facility to ensure that each one's activity needs and interests have been identified and appropriately care planned for. The Activity Director will also update staff daily in regards to the activities being planned for that day to ensure that their assistance is available to assist the residents to the appropriate activity.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p>	

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	<p>approximately 8 feet from residents' eyes, was 'on' yet the picture was grainy and fuzzy gray. There was no active television program channeled to the television set. The resident's eyes were open and were tracking physical activity immediately surrounding her.</p> <p>On 12/12/2011 at 11:50 a.m., the Social Worker was interviewed about the activities provided for Resident #12. She indicated a "QMRP"(Qualified Mental Retardation Professional) was consulted for "ideas to implement" one time a month. She indicated "...special DVD's have been ordered and wind chimes were placed above her bed for added stimulation..." in accordance to the QMRP's recommendations. She indicated there had been no specialized training or inservicing of herself or the current Activities Director in the areas of mental retardation and or developmental disabilities.</p> <p>On 12/12/2011 at 4:00 p.m., observed Resident #12 in her bed and the television was on. Her eyes were open and tracking the physical activity at her bedside. The resident was not receiving care by staff.</p> <p>On 12/13/2011 at 8:50 a.m., observed Resident #12 in bed in her room. The television was on a cartoon channel. The</p>		<p>The Administrator and Activity Director will review and audit participation records and will conduct various resident interviews at least 5 times a week for the next 30 days, then 3 times a week for 30 days. After that time, audits and interviews will be done at least weekly for the next 30 days. Any concerns that are observed or expressed by residents will be documented on the Resident Concern Form so that each can be followed up and resolved. Those forms will be reviewed by the interdisciplinary team that meets at least 5 days a week. They will update the resident's care plan in accordance with the resident's wishes and needs at that time. Once the resident's care plan is updated, the Activity Director and DON will make sure the CNA assignment sheets are updated to reflect the activity plans for each resident.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u></p> <p>The results if the observations, audits, and interviews will be reviewed with the QA Committee at least monthly for review and recommendation. The Committee may decide to stop the written audits and interviews at the end of</p>				

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	<p>resident's eyes were shut.</p> <p>On 12/13/2011 at 9:50 a.m., Resident #12 was observed in her specialized, reclining wheelchair in her room. Resident #12 was facing the doorway of her room leading into the facility's hallway. The television was on the country music channel. Resident #12's eyes were open. Resident #12 was tracking the physical activity at her side. The resident was not receiving care by staff.</p> <p>On 12/13/2011 at 10:35 a.m., observed Resident #12 in her bed. Her eyes were open and tracked physical activity at her bedside. The resident was not receiving care by staff.</p> <p>On 12/13/2011 at 2:00 p.m., observed Resident #12 in her bed. Her eyes were open and tracked physical activity at her bedside. The room lights were off. The room was dark. The resident was not receiving care by staff.</p> <p>On 12/13/2011 at 2:30 p.m., observed Resident #12 in her bed. Her eyes were open and tracked physical activity at her bedside. The overhead room light was on. The resident was not receiving care by staff.</p> <p>On 12/13/2011 at 3:30 p.m., observed</p>		<p>90 days when compliance is reached; however, as a routine the management team will continue to conduct Guardian Angel rounds during each tour of duty with their assigned residents. During those rounds, the managers will discuss upcoming activities with the residents and will document any concerns and follow thorough to resolve those concerns as part of the Resident Grievance process outlined in question #3.</p> <p><u>Date of Compliance: January 14, 2012</u></p>		

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	<p>Resident #12 in her bed. Her eyes were open and tracked physical activity at her bedside. The overhead room light was on. The resident was not receiving care by staff.</p> <p>On 12/13/2011 at 4:15 p.m., observed Resident #12 in her bed. Her eyes were open and tracked physical activity at her bedside. The overhead room light was on. The resident was not receiving care by staff.</p> <p>On 12/13/2011 at 5:30 p.m., observed Resident #12 in her bed. Her eyes were open and tracked physical activity at her bedside. The overhead room light was on. The resident was not receiving care by staff.</p> <p>On 12/14/2011 at 9:10 a.m., observed Resident #12 in her bed. Her eyes were open and tracked physical activity at her bedside. The overhead room light was on. The resident was not receiving care by staff.</p> <p>The clinical record for Resident #12 was reviewed on 12/14/2011 at 9:40 a.m.. The Minimum Data Set (MDS), dated 10/1/2011, indicated a Functional Status of '4' which,indicated: "Total dependence-full staff performance every time during 7-day period for bed-mobility, transfer,</p>				

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	<p>locomotion on unit, locomotion off unit, dressing, eating, toilet use and personal hygiene."</p> <p>The "Preferences for Customary Routine and Activities" section of the MDS, dated 10/1/2011, in Section F indicated "Listening to music" as isolated choice of pre selected 26 choices.</p> <p>The Interdisciplinary Care Plan located within Resident #12's chart was reviewed.</p> <p>The entries were as follows:</p> <p>An entry was dated "11/10 : Problem: unable to attend large group act. (activities) requiring small groups. Related to: Dx (diagnosis) profound MRDD (mental retardation developmental disability) and expressive aphasia. Goal: Res will receive 1:1 (one on one) visits 3 x (three times) week for sensory stimulation."</p> <p>Goal date of '7/2011' written underneath above entry stating, "I will attend storytime with the library volunteer every Monday when she is scheduled to come." Date(s) (of review of care plan): "2/10, 2/11, 5/11, 8/11, 10/11 and 1/12."</p> <p>"Interventions: 1). Bring resident to small group activity. 2). Provide sensory stimulation engaging in eye contact. 3). Provide resident with soothing music. 4).</p>				

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	<p>Involve resident with conversation. 5). praise all efforts. 6). have me in my room either in bed or up in my wheelchair when the library comes to visit."</p> <p>An entry dated "6/2011: Problem: I plan on living in the NF (nursing facility) longterm.: Related to: This is my preference. Goal: I will feel at home and comfortable. Date(s): 9/11, 10/11, 1/12. Interventions: 1). Encourage me to decorate my room with personal items. 2). Encourage my friends and family to visits. 3). My staff will make sure that I am comfortable. 4) Encourage me to participate in activities of interest. 5). Allow me to be as independent as possible.</p> <p>An entry dated "11/5/2010: Problem: I have indications of delirium such as inattention, altered level of consciousness, and psychomotor retardation. These indicators do not fluctuate. Related to: Dx (diagnosis) Profound MR (mental retardation). Goal: My delirium indicators will not fluctuate and or decline thru next review. Date(s): 2/11, 5/11, 8/11, 10/11, 1/12. Interventions: 1) Monitor me for fluctuations in my inattention's, altered level of consciousness and psychomotor retardation. 2) assist me to activities 3) Complete my ADL's and activities</p>				

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	<p>routinely...."</p> <p>An entry dated "11/5/10 updated for annual review: Problem: I do not always understand others and am not understood, making no decisions of my own. Related to: Dx (diagnosis) Expressive aphasia, dysphasia, profound MR. Goal: My daily needs will be anticipated and met by staff daily thru next review. Date(s): 2/11, 5/11, 8/11, 10/11 and 12/12. Interventions: ... 5) Assist me to activities ..."</p> <p>An entry dated "12/09. Problem: I am dependent on staff for all my wants and needs- I can not reposition myself- I require assist for bed mobility. Related to: I have dx of profound mental retardation. Goal: I will be repositioned q (every) 2 (hours) thru next review. Date(s): 3/10, 6/10, 8/10, 11/10, 2/11, 5/11, 8/11, 10/11 and 1/12. Interventions: ... 3) My staff to reposition me q(every) 2 (hours) at least daily..."</p> <p>Social Service Progress Notes were reviewed. The following entries were dated with entries as follows:</p> <p>Entry dated "2/14/2011: ... Resident attends some activities and receives 1:1 attention with Activity Director a couple of times a week ....(Social Worker's name)</p>				

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	<p>Entry dated "4/29/2011: ... Per staff interview it is believed that (Resident #12's name) is unaware of current season, location of room, NF placement, or staff names and faces. Writer was unable to assess LTM or STM (long-term memory/ short-term memory) r/t (related to) resident's inability to communicate. Resident had dx (diagnosis) of profound mental retardation and depends on staff to anticipate all needs..."</p> <p>Entry dated "6/15/2011: ... AD ( Activity Director) wants resident to attend at least 3 morning activities a week. Resident appears to enjoy spending time on the patio with other residents."</p> <p>Entry dated " 9/5/2011: Writer talked to resident about her new (cont) room. Resident is adjusted well to her new room but made no comment about the move."</p> <p>Entry dated "10/17/2011: QMRP: ... She is up frequently in a high back reclining w/c (wheelchair). Therapy screen completed 10/4/2011 (with)(no) recommendations. Staff provide total care (with) all ADL's and res.(resident) is transferred (with) mechanical lift. Res. (resident) receives 1:1 visits from Act. (activity) staff and attends some groups as well. Her room has a T.V., music and</p>				

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	<p>wind chimes hang from the ceiling as stimulation...."</p> <p>Entry dated "10/21/11: Annual assessment: ...She remains dependent on staff to anticipate needs for her... Resident's father is her responsible party and makes decisions on her behalf. Resident's family has little other involvement in her care and rarely visit. Resident's placement continues to be long-term...."</p> <p>Social Service MDS Supportive Documentation Tool was reviewed dated "7/9/11- 7/22/11 : ... Vision:... 7/22/2011 Resident able to follow bright objects, unable to assess if she can identify objects... Making Self Understood: 7/22/2011 Resident does not speak and has no way of making needs known. Staff anticipates all needs..."</p> <p>Activity Director Notes reviewed with entry dates and notes as follows:</p> <p>Entry dated "6/15/2011: Resident has been receiving 1:1 visits three x's (times) a week. They include time outdoors, bubbles, stories, massages, music and nail care. Each visit last about 10 minutes minimum. Resident seems to enjoy the visits as she is alert and will sometimes moan and groans during activity...."</p>				

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	<p>Entry dated "10/21/2011: ...Resident attends some group activities such as Patio Pals, current events, music entertainment and storytime with our weekly storytime volunteer. She attends 1:1 visits three times a week that include sensory stimulation such as music (spa, nature sounds), massages with lotion, painting her nails, blowing bubbles, reading to her, going outside. Resident responds to these activities such as moaning, makes eye contact, moves arms and legs, moves head around and an occasional hand squeeze..."</p> <p>Last Activity Assessment record to review was dated 11/12/2010.</p> <p>On 12/14/2011 at 9:50 a.m., the Social Worker indicated the Activity Director was not in the facility at this time, but would return later in the day.</p> <p>On 12/14/2011 at 10:00 a.m., observed Resident #12 in her bed. Her eyes were open and her eyes tracked my movement at her bedside. She was lying on her backside. The resident was not receiving care by staff. The T.V was on.</p> <p>On 12/14/2011 at 10:15 a.m., observed Resident #12 in her room in unchanged position. The T.V. was on. The resident</p>			

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	<p>was not receiving care by staff.</p> <p>On 12/14/2011 at 10:30 a.m., observed Resident #12 lying on her backside and she was moaning aloud and moving her right bent knee back and forth. The T.V. was on. The resident was not receiving care by staff.</p> <p>On 12/14/2011 at 11:00 a.m., observed Resident #12. Her position was unchanged. Her eyes were open and she tracked my movement at her bedside. She was lying on her backside. The resident was not receiving care by staff.</p> <p>On 12/14/2011, between 11:21 a.m. and 11:24 a.m., RN #4, the treatment nurse, was observed to enter Resident #12's room and close the door. At 11:22 a.m., the Dentist was observed to knock on the door and then walk away. At 11:24 a.m., the RN #4 exited the resident's room. The resident was observed in her bed, at this time. Her eyes were teary and alert. The T.V. was on.</p> <p>On 12/14/2011 at 12:30 p.m., Resident #12 was observed at her bedside. The T.V. was on. Her position was unchanged. She was lying on her back side. Her eyes were open and she was moving her right bent leg, and wiggling her knee back and forth. She tracked</p>				

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	<p>movements at her bedside. The resident was not receiving care by staff.</p> <p>On 12/14/2011 at 12:50 p.m., observed Resident #12 in her bed. Her position was unchanged. She was lying on her backside. The T.V. was on. The resident was not receiving care by staff.</p> <p>On 12/14/2011 at 1:15 p.m., observed Resident #12 in her bed. Her position was unchanged. She was lying on her backside. The T.V. was on. The resident was not receiving care by staff.</p> <p>On 12/14/2011 at 1:30 p.m., observed Resident #12 in her room. Her position was unchanged. She was lying on her backside. The T.V was on. The resident was not receiving care by staff.</p> <p>On 12/14/2011 at 2:00 p.m., the last observation for the day was made of Resident #12 in her room. Her position was unchanged from my last entry observation at 10:00 a.m. She was lying on her backside. The T.V. was on. The resident was not receiving care by staff.</p> <p>On 12/15/2011 at 8:05 a.m., Resident #12 was observed at her bedside in her bed in her room. The T.V. was on. Her eyes were open and she tracked movements in her room. The resident was not receiving</p>			

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	<p>care by staff.</p> <p>On 12/15/2011 at 9:20 a.m., observed Resident #12 in her bed in her room. The T.V. was on. Her eyes were open and she tracked movements in her room. The resident was not receiving care by staff.</p> <p>On 12/15/2011 at 10:00 a.m., the Activity Director provided records of the facility's activities calendars for 2011 with highlighted passive and active participation for Resident #12. A note at the top of calendar indicated "1:1 3x's wk (week) 10 min (minutes)" Entries as follows:</p> <p>Entry dated for active participation ( highlighted in yellow marker) in group activities for December: 12/1 at 11:00 a.m. Funnerciser 12/7 at 11:00 a.m. Energizers 12/12 at 11:00 a.m. Energizers No passive participation (highlighted in pink marker) indicated for December.</p> <p>Entry dated for active participation in group activities for November 2011: 11/3 at 10:00 and 11:00 a.m. for current events, coffee and Funnerciser. 11/8 at 11:00 a.m. Funnerciser 11/22 at 11:00 a.m. Funnerciser 11/29 at 11:00 Funnerciser No passive participation (highlighted in</p>				

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	<p>pink marker) indicated for November 2011.</p> <p>Entry dated for active participation in group activities for October 2011: 10/10 at 11:00 a.m. Energizers 10/17 at 11:00 a.m. Energizers No passive participation (highlighted in pink marker) indicated for October 2011.</p> <p>Entry dated for active participation in group activities for September 2011: 9/10 at 11:00 a.m. Energizers No passive participation (highlighted in pink marker) indicated for September 2011.</p> <p>Entry dated for active participation in group activities for August 2011: 8/1 at 10:00 a.m. Build a Bear Workshop w/ RSVP 8/1/ at 11:00 a.m. Energizers 8/1 at 2:30 p.m. Reading with Cheryl 8/1 at 6:00 p.m. Piano with Pat 8/9 at 11:00 a.m. Energizers 8/15 at 11:00 a.m. Energizers 8/19 at 11:00 a.m. Energizers 8/26 at 11:00 a.m. Energizers 8/30 at 11:00 a.m. Energizers 8/31 at 11:00 a.m. Energizers No passive participation (highlighted in pink marker) indicated for August 2011.</p> <p>Entry dated for active participation in</p>			

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	<p>group activities for July 2011: 7/26 at 10:00 Patio Pals 7/26 at 11:15 a.m. Energizers 7/28 at 11:00 a.m. Energizers 7/29 at 11:00 a.m. Energizers No passive participation (highlighted in pink marker) indicated for July 2011.</p> <p>On 12/15/2011 at 8:00 a.m., the Activity Director was interviewed about her 1:1 activities with Resident #12. She indicated the Care Plan was to do 1:1's 3 times a week to which she routinely complies. Indicated her 1:1 was last done on "... this Monday..."</p> <p>On 12/15/2011 at 10:00 a.m., reviewed "Activity Director's Individual Program Plan" for Resident #12 with the Activity Director and DON (Director of Nursing) at Resident #12's bedside. Resident #12 was observed tracking the physical activity at her bedside and wiggling her knees back and forth by her own doing.</p> <p>The Activity Director's entries included the date of the entry, the time spent with Resident #12, the activity and the resident's response noted as follows:</p> <p>December 2011 12/2- 15 minutes. lotion massage and nails. Moaned, moved legs. 12/5- 10 minutes. played x-mas music and</p>				

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	<p>sand. in and out of sleep. 12/7- 10 minutes. read x-mas stories. Made eye contact. 12/9- 10 minutes. played x-mas music and sang. moaned a lot. 12/12- 10 minutes. wind chimes. read new daily bread reader. looked around at sounds of chimes. November 2011 11/2- 10 minutes. reading. looked around. 11/4. 10 minutes. wind chimes, massage. gazed at ceiling/ moved head a lot. 11/7- 40 minutes. volunteer reader. moaned moved hands. 11/9- 15 minutes. nails. moved hands but calm enough to paint. made eye contact. 11/10- 10 minutes. spa music/ instrumental. fell asleep. 11/11- 10 minutes. read short story. made eye contact. 11/15- 10 minutes. sang song. bubbles. moaned/ looked at bubbles floating. 11/16- 10 minutes. music. country songs. deep moans throughout the 2 songs. 11/17- 10 minutes. painted nails w/lotion massage. moved hands and legs. 11/22- 10 minutes played chimes, blew bubbles. made eye contact with both (activities) 11/23- 10 minutes. chicken soup stories. looked around 11/25- 10 minutes. spa music, nails and lotion massage. moved hands around and moaned.</p>				

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	<p>11/28- 10 minutes. showed different x-mas ornaments. let her feel all the different ornaments. talked about putting up the x-mas tree. Made eye contact with the ornaments.</p> <p>12/15 2011 at 10:30 a.m., interviewed the Director of Nursing (DON) about care and activities of Resident #12. The DON indicated the care of the Resident had, "...been this way for along time..." She was queried about lack of activities provided for Resident #12 during the days of observations during the survey and she indicated this is the way it was usually done. The DON indicated the tube feeding pump was not a deterrent for transferring Resident #12 to her wheelchair yet indicated that Resident #12 had "physical issues" that prevent her from transferring. The DON was unable to indicate what the physical issues were that prevented involvement of Resident #12. The DON indicated the primary responsibility for transferring and providing access to the activities was the C.N.A's (Certified Nurse Aids).</p> <p>12/15/2011 at 10:30 a.m., observed C.N.A. taking the mechanical lift into Resident #12's room.</p> <p>12/15/2011 at 10:40 a.m., observed Resident #12 in her wheelchair at her</p>				

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F0309 SS=D	<p>bedside. The resident raised her head in response to the sound of shoe heels clicking on the floor.</p> <p>12/15/2011 at 1:00 p.m., Resident #12 was observed up in her wheelchair with her tube feeding connected. Her eyes were open, her head was lifted and her television was on.</p> <p>3.1-33(a)</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 record review and interview, the facility failed to provide an ongoing assessment in regards to a resident who received dialysis for end stage renal disease, for 1 of 1 resident receiving dialysis in a sample of 10. (Resident #22)</p> <p>Finding include:</p>	F0309	<p>F309 Provide Care and Services for highest Well Being</p> <p>It is the standard and policy of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with each resident's comprehensive assessment and plan</p>	01/14/2012	

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	<p>The record of Resident #22 was reviewed on 12/12/11 at 9:00 a.m. Resident #22 was admitted to the facility with diagnoses including, but not limited to hypertension, diabetes, anxiety, and end stage renal disease. The resident left the facility three days a week for dialysis.</p> <p>Review of the resident's dialysis book (a binder for communication between the dialysis unit and the facility, including but not limited to, dialysis site assessments, labs, and weights) indicated a facility form, titled, "Post Dialysis Assessment." The form directed facility staff to a check list to assess the shunt site (access port for the dialysis treatment) and vital signs after return from the dialysis outpatient unit. The binder contained numerous completed forms with the most current dated 10/21/11.</p> <p>Review of Care Plan, dated 06/01/11, indicated: "Problem: I have new fistula- I receive dialysis R/T (related/to) diabetes and kidney disease.... Interventions: 09/01/11, 12/11: 1. I will continue to go to dialysis 3 X wk (times week) M-W-F (Monday-Wednesday-Friday). 2. ... staff to check for Bruit and Thrill q (every) shift. (way of checking adequacy</p>		<p>of care, including provision of ongoing assessment for residents who receive dialysis.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> The licensed nursing staff was re-trained on the policy and procedure for assessment of residents who receive dialysis services on January 5, 2012, including performing a post dialysis assessment after the resident returns from each dialysis session and documenting the results of that assessment. (see attachment) <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u> There were no other residents affected by this practice. However, if the DON finds that documentation of appropriate assessment of dialysis residents is not occurring, she will make sure that the assessment occurs as quickly as possible. Once that is done and documented, she will retrain the staff involved regarding the facility's policy and procedure for assessment and documentation of dialysis residents' status. She will also render progressive disciplinary action for episodes of continued noncompliance.</p>		

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	<p>of dialysis port)..."</p> <p>The DNS (Director Nursing Services) was interviewed on 12/12/11 at 1:00 p.m. The DNS indicated being unaware of the facility's form. The DNS indicated the facility did not have any Policy and Procedure in regards to post dialysis assessments.</p> <p>3.1-37(a)</p>		<p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>A post dialysis assessment will be done on every resident who receives dialysis services after his/her return to the facility. Bruit, thrill, and fistula site will be assessed every shift and documented daily per the documentation listing.</p> <p>The DON or designee will monitor the nurse's documentation at least 5 times per week for 30 days , then 3 times per week for 30 days to make sure that the follow up assessment is completed and documented. Any identified issues will be dealt with as outlined in question #2.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u></p> <p>The Director of Nursing will bring the results of the audits to the monthly QA committee for review and recommendations. Once 100% compliance is reached at the end of the 60 day period, the QA committee may decide to stop the documented audits, however the DON will continue checking the dialysis assessment documentation at least weekly on an ongoing basis.</p> <p><u>Date of Compliance: January 14, 2012</u></p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observations and staff interviews, the facility failed to store dry foods in manner preventing possible bug infestation, failed to discard outdated foods, and failed to assure all opened consumable goods were properly labeled. This potentially affected 21 of 22 residents who received their daily meals from the facility kitchen..</p> <p>Findings include:</p> <p>On 12/12/2011 at 7:30 a.m., observations were made upon the initial tour of the kitchen with Cook #6.</p> <p>At 7:30 a.m., observations of Dietary Cook #6 were made of cross contamination between plastic hand-gloves and raw eggs with the ready to eat food for the residents being served. Cook #6 cracked raw eggs for frying, placed the raw egg into a hot skillet allowing the white raw egg substance to drip onto her plastic gloves. She proceeded to dish up cooked oatmeal into a bowl being served to a resident and touched a cold juice glass afterwards. Her gloves were not changed through out the</p>	F0371	<p>F371 Food Procure Store/Prepare/Serve - Sanitary</p> <p>It is the standard and policy of this facility to store, prepare, distribute, and serve food in a sanitary manner including appropriate storage of dry foods, discarding of outdated foods, and labeling of opened foods.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>All dietary staff was in-serviced on December s9, 2011, in regards to proper procedures for food handling, washing hands, changing gloves, storage of food, and discarding of food.</p> <p>All dietary employees received a copy of the policy for proper food storage, and each received written counseling regarding proper handling and discarding of food.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>No residents were affected by this practice. However, if the Dietary Manager or Administrator observes or finds an issue with proper food storage, handling, or hand washing, the employee will be stopped at that</p>	01/14/2012	

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	<p>process of cooking raw eggs for consumption and the handling of other immediate consumable foods.</p> <p>At 7:32 a.m. the Dietary Cook #6 indicated the thawing of consumable meats was completed in the disinfecting portion of the 3 sink area without the use of water.</p> <p>12/12/2011 at 7:35 a.m., observations were made inside of the refrigerator within the kitchen area. An unlabeled glass jar filled a third full of sauerkraut was not dated, a large block of yellow cheese inside of a gallon zip-lock plastic type baggy was not labeled or dated, a 46 ounce container of concentrated nectar thickened orange juice was labeled/marked "8/3" in black Sharpie pen., and a gallon plastic milk jug filled to 1 tenth full of white substance was not dated.</p> <p>12/12/2011 at 7:40 a.m., observations were made in the dry storage area. A large heavy paper-type bag labeled GFS Cracker Meal was opened 11/7 as noted by a handwritten date on the side of the bag. The bag was not being stored within a plastic securable type bin. Two large plastic bins printed with Rubbermaid were each filled with dry, powdery</p>		<p>time and re-trained on the proper procedure. In addition, progressive disciplinary action will be given for instances of continue noncompliance.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u> The Dietary Manager or designee will check food items daily to ensure that they are labeled and discard timely. The Dietary Manager or designee will perform audits of food practices at least 5 times a week for 30 days, then 3 times per week for 30 days until the staff is 100% compliant. Any identified concerns will be handled as outlined in question #2.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u> The Dietary Manager will bring results of audits to the monthly QA committee meeting for review and recommendation. The QA committee may decide to stop the written audits once the 60 days has elapsed and 100% compliance has been demonstrated; however, the Dietary Manager will continue to check food items daily and to observe for appropriate handwashing as part of her routine during each tour of duty.</p> <p><u>Date of Compliance: January 14,</u></p>		

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	<p>substances resembling 'flour/ sugar' and scoops for transferring the substances from the holding bins to the useable area were located inside the bins. One scoop was laying in the substance. A large container labeled 'White Icing' was not dated of purchase. 10-14 ounce cans of Eagle Brand condensed milk were not dated of purchase.</p> <p>12/13/2011 at 9:00 a.m., the Dietary Manager was interviewed. Dating of consumable goods was discussed. She indicated the kitchen did not have a current procedure of dating goods as they were opened upon use. All items dated in black Sharpie markers were indicative of purchase dates. All items in the refrigerator were not dated upon opening to actively use.</p> <p>12/13/2011 at 9:10 a.m., the Dietary Manager indicated it was knowledge that the Cook #6 had completed thawing consumable meats in the manner of thawing in a dry sink area versus in the refrigerator or with water in a sink area. "I've (the dietary manager) have had to tell her not to do that before...."</p> <p>3.1-21(i)(2)</p>		2012		

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>A. Based on observations, record reviews, and interview, the facility failed to ensure the policy for administration of oral medications was followed related to a nurse dispensing medications into her hands from the medication blister packs. This deficiency affected 2 of 8 residents observed who received oral medications during the medication pass observation. (Resident #17 and Resident # 18.)</p> <p>B. Based on observations, record review, and interview, the facility failed to follow their policy to ensure 2 medication capsules were destroyed correctly. This deficiency affected 1 of 8 residents</p>	F0425	<p>F425 Pharmaceutical Services It is the standard and policy of this facility to provide routine and emergency drugs and biologicals to its residents, including following the policy for appropriate administration of medications to residents and to make sure that medications are destroyed properly.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Licensed nurses were re-inserviced on January 5, 2012, regarding proper procedures for medication administration and destruction of medication. They were required to give a return demonstration for medication administration skills at</p>	01/14/2012	

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	<p>observed during the medication pass observation. (Resident #1)</p> <p>Findings include:</p> <p>A.1. On 12/13/11 at 4:25 p.m., during observation of the medication pass, RN #4 removed from Resident #17's medication blister packages 1 calcium 600 milligrams (mg) and 1 vitamin D 400 units and placed them in her hand before she poured them into a souffle cup.</p> <p>A.2. On 12/13/11 at 4:45 p.m., during observation of the medication pass, RN #4 removed 1 Coreg 6.25 mg, 1 poly-iron 150 mg, 1 Lasix 40 mg, and 1 Tramadol 50 mg from Resident #18's medication blister packages and placed the oral medications in her hand before she placed them in a souffle cup.</p> <p>An interview with RN #4 on 12/13/11 at 5:00 p.m., in regard to placing the oral medications in her hand prior to placing them in a souffle cup. RN #4 indicated she should not have placed the oral medications in her hand and she should have placed them directly in the souffle cup.</p> <p>On 12/14/11 at 8:30 a.m., the Oral Medication Administration policy, dated June 2011, indicated "...For Solid</p>		<p>that time.</p> <p>The nurse involved in the noncompliance at the time of survey has received disciplinary action for her deficient practice.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>There were no residents affected by this practice; however, if noncompliance is observed while a nurse is administering or destroying medications, they will be stopped immediately and their performance corrected. Once the administration or destruction is performed correctly, they will be retrained by the DON regarding the facility policies for each. In addition, progressive disciplinary action will be given.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>The DON or designee will randomly audit each licensed nurse 3 times a week for the first week; thereafter, she will audit the licensed nurses at least one time a week for the next 30 days. After that time, she will audit each one at least quarterly for proper performance for the next 6 months.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what</u></p>		

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	<p>Medications 1. Pour the correct number of tablets or capsules into the souffle cup...."</p> <p>B.1. On 12/12/11 at 8:00 a.m., LPN #2 was observed to administer medications to Resident #1. LPN #2 made two different attempts to give Resident #1 a Keflex (antibiotic) capsule. Each time the resident removed the capsule from her mouth and would not swallow the medication. LPN #2 was observed to flush the two Keflex capsules down the hopper.</p> <p>On 12/14/11 at 1:00 p.m., received from the Director of Nursing the General Medications Policy revised 7/2007 indicated "...5. Oral solid dosage forms should be flushed down the toilet..."</p> <p>On 12/14/11 at 1:30 p.m., a request was made of the Director Of Nursing (DON) for the most current medication disposition policy.</p> <p>On 12/15/11 at 1:45 p.m., received from the DON the "Medication Destruction" policy, dated 1/2010. The policy included "...A. Do not flush prescription drugs down the toilet or drain unless the package insert specifically instructs you to do so...B. to dispose of non-flushable</p>		<p><u>quality assurance program will be put into place?</u></p> <p>The DON will bring the results of her audits to the monthly QA committee meeting for review and recommendation. Once the audits are completed and 100% compliance has been reached, the QA committee may decide to stop the written audits. The DON will continue to monitor the nurse's performance during medication administration and destruction on an ongoing basis as part of her regular duties.</p> <p><u>Date of Compliance: January 14, 2012</u></p>				

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	<p>prescription drugs: 1) The facility may be able to take advantage of a community take-back program or other program that collects drugs at a central location for proper disposal, or; 2)...a. Remove medications from their original containers. b. Mix drugs with an undesirable substance, such as cat litter or used coffee grounds. c. Put the mixture into a disposable container with a lid, such as a 5 gallon bucket, or into a sealable bag. Place in an opaque bag and dispose of in the trash...."</p> <p>On 12/15/11 at 1:55 p.m., an interview with the Director Of Nursing (DON) in regard to the disposal of the two Keflex capsules down the hopper. The DON indicated LPN #2 should not have flushed the two Keflex capsules down the hopper. The DON further indicated she is unsure why the facility did not follow the most current Drug Destruction policy.</p> <p>3.1-25(a) 3.1-25(o)</p>				

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, record review and interviews, the facility failed to follow their Infection Control policy and procedures in regards to placing soiled items on an over thebed table, failing to</p>	F0441	<p>F 441 Infection Control Prevent Spread, Linens It is the standard and policy of this facility to establish and maintain an infection control program, including</p>	01/14/2012

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	<p>ensure hands were washed and gloves were used appropriately during resident care observations including dressing changes and glucometer checks. This affected 4 of 10 residents reviewed for infection control practices in the sample of 10.</p> <p>(Residents #17, #18, # 7, # 15)</p> <p>Findings include:</p> <p>1. Resident #17 was identified, by LPN #2, during the initial tour, on 12/11/11 between 7:00 a.m. and 7:30 a.m., as having a supra-pubic catheter (a urinary catheter inserted through a surgical opening in the abdominal wall) and receiving a catheter care/cleansing to the catheter site every shift. On 12/12/11 at 10:30 a.m., LPN #2 was observed doing the supra-pubic catheter care for Resident #17. LPN #2 utilized three washcloths, one to cleanse, one to rinse, and one to dry the site area. Following the usage of each washcloth, LPN #2 was observed to place the soiled washcloths directly on the unprotected over the bed table. Following the removal of the soiled washcloths, LPN #2 did not clean the over the bed table and placed the table near Resident #17 for access to the water pitcher and personal items on the table.</p>		<p>policies and procedures in regards to handling soiled items, hand washing, and appropriate glove use.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>All staff was re-inserviced on the policy and procedure for hand washing. Each staff member performed a return demonstration on proper hand washing procedures. In addition, all licensed nurses and CNAs were re-inserviced on proper placement of articles on resident furniture, such as the overbed table, and proper glove use. A returned demonstration and successful skills checklist was done for each. The nurse and CNAs who displayed deficient practices during the survey have been re-inserviced and have received disciplinary action.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>No other residents were affected by this practice. If any staff are observed not to follow the facility procedures for hand washing, glove use, or soiled item placement, they will be stopped immediately by the manager who observes them. The DON or Administrator will re-train the staff involved at that time regarding the proper policy and procedure and will render</p>				

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	<p>2. Resident #17 was observed to put her call light on at 10:10 a.m., on 12/12/11. Resident #17 was dressed and lying in bed. CNA #7 entered the resident's room, lifted the legs of Resident #17 and placed two pillows under Resident #17's thighs as requested. CNA #7 was then observed to leave the resident's room without washing her hands and cross the hallway to assist another resident who required assistance.</p> <p>3. Resident #17 was observed during a standing lift transfer, from the bed to wheelchair, assisted by the DNS (Director Nursing Services) and CNA #5. CNA #5 left the room following the transfer, obtained linens from a utility room, returned to the room of Resident #17 and then exited to answer another resident's call light. CNA #5 did not wash her hands at any time prior to assisting with the transfer of Resident #17, following the transfer or prior to responding to the call light.</p> <p>4. On 12/13/11 at 4:25 p.m., during medication administration, RN #4 was observed as she removed from Resident #17's medication blister packages 1 calcium 600 milligrams (mg) and 1 vitamin D 400 units and placed them in</p>		<p>progressive discipline for continued noncompliance.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u> The Director of Nursing or designee will randomly observe hand washing and dressing changes with the applicable nursing staff at least 3 times per week for 30 days, then weekly for the next 30 days. Observed issues will be addressed as outlined in question #2.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u> The Director of Nursing will bring the results of her observations to the monthly QA committee meeting for review and recommendation. Once the 60 days is completed, the QA committee may decide to stop the written observations once 100% compliance is reached. The Director of Nursing will continue random observations on an ongoing basis as part of her routine duties. <u>Date of Compliance: January 14, 2012</u></p>		

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	<p>her hand before she poured them into a souffle cup.</p> <p>5. On 12/13/11 at 4:45 p.m., during medication administration, RN #4 was observed as she removed 1 Coreg 6.25 mg, 1 poly-iron 150 mg, 1 Lasix 40 mg and 1 Tramadol 50 mg from Resident #18's medication blister packages and placed the oral medications in her hand before she placed them in a souffle cup.</p> <p>An interview with RN #4 on 12/13/11 at 5:00 p.m., in regard to placing the oral medications in her hand prior to placing them in a souffle cup. RN #4 indicated she should not have placed the oral medications in her hand and she should have placed them directly in the souffle cup.</p> <p>On 12/14/11 at 8:30 a.m., the Oral Medication Administration policy dated June 2011 indicated "...For Solid Medications 1. Pour the correct number of tablets or capsules into the souffle cup...."</p> <p>6. On 12/13/11 at 3:50 p.m., RN #4 was observed in Resident #7's room as she applied gloves to both hands and cleansed the resident's finger and obtained a drop of blood with a lancet and applied the blood to the glucometer test strip. RN #4</p>			

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	<p>gathered her supplies and left the resident's room with her gloves on her hands and proceeded to her medication cart where she disposed of her supplies. RN #4 removed her gloves and applied new gloves and cleaned the glucometer machine; then she removed her gloves and cleaned both of her hands with antiseptic gel.</p> <p>7. On 12/13/11 at 4:15 p.m., during the medication administration, RN #4 was observed at the medication cart and applied gloves to both hands. RN #4 gathered the glucometer machine and entered Resident #15's room with her hands gloved. RN #4 cleansed the resident's finger with an alcohol pad, obtained a drop of blood with a lancet then applied the drop of blood onto the test strip that was in the glucometer machine for the resident's blood sugar. RN #4 left the resident's room with the gloves still on her hands. RN #4 removed the right glove in the hallway. RN #4 went to the medication cart and opened the drawer and removed a disposable antiseptic wipe and cleaned the glucometer machine. RN #4 then removed the glove from her left hand and disposed of the glove in the trash. RN #4 then cleansed both her hands with antiseptic gel.</p>				

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	<p>On 12/14/11 at 2:15 p.m., the Director Of Nursing (DON) was interviewed in regard to leaving the residents' rooms with gloves on RN #4 hands. The DON indicated the gloves should had been removed and RN #4 should have washed her hands prior to leaving the residents' rooms.</p> <p>8. On 12/13/11 at 4:30 p.m., RN #4 was observed to provide wound care for Resident #17. RN #4 washed her hand for 20 seconds and applied gloves. RN #4 removed the old dressing from the resident's left ankle then removed gloves and washed her hands with soap and water for 7 seconds and then applied gloves. RN #4 cleansed the wound with normal saline; then she reached into her pocket and removed a pair of scissors and proceeded to cut off a piece of Aquacel AG dressing. RN #4 put the scissors back into her pocket without cleaning them. RN #4 applied the Acquacel AG dressing to the wound bed and reached back into her pocket and removed the scissors and cut a piece of Meplex dressing and placed over the Acquacel AG dressing. RN #4 placed the scissors back into her pocket without cleaning them. RN #4 removed her gloves and washed her hands with soap and water for 12 seconds.</p> <p>Review of a Policy and Procedure, titled</p>				

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	<p>"Handwashing/Alcohol-Based Hand Tub", dated 7/2010 and provided by the DNS (Director Nursing Services) on 12/14/11, indicated:</p> <p>"PURPOSE: Medical asepsis to control infection.</p> <p>To reduce transmission of organisms from resident to resident.</p> <p>To reduce transmission of organisms from nursing staff to resident.</p> <p>To reduce transmission of organisms from resident to nursing staff.</p> <p>Guidelines: ...personnel should always wash their hands (even when gloves are worn;</p> <p>After gloves are removed; ...</p> <p>Before and after touching wounds, whether surgical, traumatic, or associated with an invasive device;</p> <p>After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes...</p> <p>After touching inanimate sources that are likely to be contaminated with virulent or epistemologically important microorganisms (including urinary catheter components...</p> <p>Before and after using the toilet;...</p> <p>Before and after each resident contact;</p> <p>After touching a resident or handling his/her belongings;..."</p>			

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F0465 SS=F	<p>Handwashing procedure:...</p> <p>2...Wash up to your wrist...Do this for at least 20 seconds..."</p> <p>3.1-18(l)</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and staff interview, the facility failed to ensure the flooring in the kitchen and storage room was clean and free of litter and debris during 3 of 3 kitchen observations. This had the potential to affect 21 of 22 residents who received meals from the facility kitchen.</p> <p>Findings include:</p> <p>12/12/2011 at 7:30 a.m., observations were made upon the initial tour of the kitchen with Cook #6. The kitchen floor and dry storage area floor was littered with particles of dirt and grit. A sugar packet was lying on the kitchen floor by the 3-sink dirty dish area. The overall appearance of the kitchen floor was dingy and dirty. The storage area floor was gritty under foot and dirty in appearance.</p> <p>12/13/2011 at 9:00 a.m., the Dietary</p>	F0465	<p>F 465 Safe/Functional/Sanitary/Comfortable Environments</p> <p>It is the standard and policy of this facility to provide a safe, functional, sanitary, and comfortable environment, including clean flooring in the kitchen and storage area.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Dietary staff was re-inserviced on December 9, 2011 regarding proper care of equipment and floors in the kitchen and storage areas. The Dietary Manager was re-inserviced on proper techniques and the expected cleanliness of the kitchen. The kitchen was deep cleaned on December 22, 2011 which included taking all equipment out of the kitchen and scrubbing the floor with a degreaser, utilizing a floor scrubber machine.</p> <p><u>How other residents having the</u></p>	01/14/2012	

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	<p>Manager was interviewed about the condition of the floors in the dry storage area and the kitchen areas. She indicated the floors were dirty and she could not remember when they had been thoroughly cleaned.</p> <p>12/13/2011 at 9:36 a.m., a record review was made of the cleaning schedule of the kitchen provided by the Dietary Manager. The Cleaning Schedule had no dates and one horizontal column was completed with initialed coded letters indicating 'D' for daily and 'W' for weekly. The column 'Floors' was noted with a 'D'.</p> <p>12/14/2011 at 11:30 a.m., observed the kitchen floors for cleanliness. The floors remained the same as observed upon initial tour on 12/12/11.</p> <p>3.1-19(f)</p>		<p><u>potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>No residents were affected by this practice. If the Dietary Manager or Administrator observes an issue with kitchen cleanliness at any time in the future, the staff involved will be re-trained on the facility policy and procedures for cleaning the kitchen and equipment. The Dietary Manager or Administrator will also supervise the staff to make sure that the concern is taken care of quickly as possible. Progressive disciplinary action will also be rendered for continued noncompliance.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Scrubbing of the kitchen floor was added to the monthly cleaning schedule. Mopping of floors is on the daily cleaning schedule, and dietary staff was re-inserviced on the process of mopping daily and between shifts to make sure that the floor is clean.</p> <p>The Dietary Manager or designee will monitor the kitchen and storage areas on a daily basis to make sure that the floor and equipment are clean and will document findings. The Dietary manger or designee will audit the environment for the kitchen and storage area 5 times per week for 30 days and then 3 times</p>		

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			<p>per week for 30 days to ensure completion and cleanliness of areas is maintained. The Dietary manager will monitor on a routine basis as part of her daily tasks proper cleaning is maintained in the kitchen and the storage area on an ongoing basis.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u></p> <p>The Dietary Manager will report results of her audits and observations to the QA committee at least monthly. The QA committee may decide to stop the documented audits after the 60 day period once 100% compl9iance is reached. Even when the documented audits are stopped, the Dietary Manager or designee will continue to observe the dietary staff's performance and the cleanliness of the kitchen and equipment on an ongoing basis with appropriate re-training and counseling.</p> <p><u>Date of Compliance: January 14, 2012</u></p>		

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>A.1. Based on record review and interview, the facility failed to transcribe a sliding scale insulin order following an order change from the admission orders to the facility for 1 of 3 residents receiving sliding scale insulin in a sample of 10. (Resident #22)</p> <p>B.1. Based on observation, record review, and interview, the facility failed to ensure documentation was complete in the resident's clinical record in regard to the disposal of two Keflex capsules. This deficiency affected 1 of 1 resident who was observed to refuse 2 Keflex capsules during the medication pass observation.</p> <p>Finding includes:</p> <p>A.1. The record of Resident #22 was reviewed on 12/12/11 at 9:00 a.m. Resident #22 was admitted to the facility with diagnoses including, but not limited to, diabetes, anxiety, insomnia, and end</p>	F0514	<p>F514 Records Complete/Accurate/Accessible</p> <p>It is the standard and policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, including transcription of insulin orders and appropriate documentation of medication destruction.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident #22 continues to receive her insulin following the sliding scale as ordered.</p> <p>Resident #1 did not miss any doses of her ordered antibiotic.</p> <p>The licensed nurses were re-inserviced on January 5, 2012 regarding the procedure for order transcription, medication administration, and disposal of contaminated, refused, or discontinued medication.</p> <p><u>How other residents having the</u></p>	01/14/2012	

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	<p>stage renal disease.</p> <p>Review of admission orders from an ACF (Acute Care Facility: hospital), indicated: "07/28/2011: Humalog Insulin Subcutaneous: Three times a day before meals and daily at bedtime: BS (Blood Sugar): 121-150: 1 unit 151-200: 2 unit 201-250: 3 unit 251-300: 4 unit 301-350: 6 unit..."</p> <p>The MAR (Medication Administration Record), dated 08/01/2011, had the 07/28/2011 order crossed through and written, "orders ^d (changed) for coverage 8/10/11." The changed order indicated: "Humalog insulin unit sliding scale sub-q (subcutaneous): 200-250= 1 unit 250-300= 3 unit 300-350= 5 unit"</p> <p>Review of the resident's record and thinned record did not include an order for the medication change.</p> <p>Review of Physician Order Sheets, dated and signed, 08/2011, 09/2011, 10/2011, 11/2011, and 12/2011 indicated: "Humalog insulin unit sliding scale sub-q</p>		<p><u>potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>No residents were affected by this deficient practice.</p> <p>During the week of December 26, 2011 the Director of Nursing reviewed the January 2012 physician order monthly rewrites for all residents. There were no other transcription errors identified. In the future, if the Director of Nursing finds that an order has not been transcribed properly or that documentation if medication disposal is not complete or accurate, she will re-train the staff involved on the facility policy and procedure. She will also render progressive disciplinary action for continued noncompliance.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>The Director of Nursing or designee will review physician orders and nursing documentation at least 5 times a week on an ongoing basis. She will review copies of physician telephone orders to make sure that any changes in physician orders are transcribed appropriately.</p> <p>The Director of Nursing or designee will audit medication administration records 5 times per week for 30 days, then weekly for the next 30 days to ensure that any refusal of</p>		

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	<p>(subcutaneous): 200-250= 1 unit 250-300= 3 unit 300-350= 5 unit"</p> <p>The subsequent signed physician orders correlated with the order change on the MAR.</p> <p>The DNS (Director Nursing Services) was interviewed on 12/12/11 at 1:00 p.m. The DNS indicated a telephone order should have been written.</p> <p>Review of a Policy and Procedure, dated 06/2004 and titled, "Telephone Orders", as provided by the DNS for medication order transcription, indicated: "PURPOSE: To obtain orders for care and treatment of the resident as necessary.... PROCEDURE: 1. Obtain new order or change of order from physician. 2. Write new order on telephone order form. 3. Record date and time order was received.... 6. Write order on medication and/or treatment record exactly as written on the telephone order form...."</p>		<p>medication is documented appropriately, and that discontinued medications are disposed of and documented following procedure. Any identified issues or concerns will be addressed as outlined in question #2.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u> Results of the Director of Nursing's audits will be forwarded to the Administrator and then reviewed by the QA committee at its monthly meeting. This will occur for at least 60 days. After that time the QA committee may stop the documented audits when 100% compliance is achieved. The Director of Nursing will continue to check physician telephone orders and nursing documentation at least 5 times a week on an ongoing basis as indicated in question #3. <u>Date of Compliance: January 14, 2012</u></p>		

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	<p>B.1. On 12/12/11 at 8:00 a.m., LPN #2 was observed to attempt to administer to Resident #1 two Keflex capsules. Each time the resident removed the capsules from her mouth. LPN #2 was observed to dispose of the Keflex medication in the hopper.</p> <p>On 12/14/11 at 8:45 a.m., the Nurse's notes and the Medication Administration Record (MAR) for 12/12/11 were reviewed for Resident #1 and there was no documentation to indicate the two Keflex capsules were disposed of in the hopper.</p> <p>On 12/14/11 at 9:00 a.m., an interview with the Director Of Nursing (DON) in regard to no documentation for the disposal of the two Keflex capsules. The DON indicated the two Keflex capsules should have been documented on the back of the resident's MAR.</p> <p>Review of a Policy and Procedure, titled, "Disposal of Medications and Medication Related Supplies-01/2010", received from the Director Nursing Services on 12/15/11 at 1:45 p.m., indicated: "...E. Licensed nurse...witnessing the destruction ensures that the following info is entered on the (medication disposal form)..."</p>	F0514	<p>F514 Records Complete/Accurate/Accessible It is the standard and policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, including transcription of insulin orders and appropriate documentation of medication destruction.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #22 continues to receive her insulin following the sliding scale as ordered. Resident #1 did not miss any doses of her ordered antibiotic. The licensed nurses were re-inserviced on January 5, 2012 regarding the procedure for order transcription, medication administration, and disposal of contaminated, refused, or discontinued medication.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u> No residents were affected by this deficient practice. During the week of December 26, 2011 the Director of Nursing reviewed the January 2012 physician order monthly rewrites for all residents. There were no other</p>	01/14/2012	

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	3.1-50(a)(1) 3.1-50(a)(2)		<p>transcription errors identified.</p> <p>In the future, if the Director of Nursing finds that an order has not been transcribed properly or that documentation if medication disposal is not complete or accurate, she will re-train the staff involved on the facility policy and procedure. She will also render progressive disciplinary action for continued noncompliance.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>The Director of Nursing or designee will review physician orders and nursing documentation at least 5 times a week on an ongoing basis. She will review copies of physician telephone orders to make sure that any changes in physician orders are transcribed appropriately.</p> <p>The Director of Nursing or designee will audit medication administration records 5 times per week for 30 days, then weekly for the next 30 days to ensure that any refusal of medication is documented appropriately, and that discontinued medications are disposed of and documented following procedure. Any identified issues or concerns will be addressed as outlined in question #2.</p> <p><u>How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be</u></p>		

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			<p><u>put into place?</u></p> <p>Results of the Director of Nursing's audits will be forwarded to the Administrator and then reviewed by the QA committee at its monthly meeting. This will occur for at least 60 days. After that time the QA committee may stop the documented audits when 100% compliance is achieved. The Director of Nursing will continue to check physician telephone orders and nursing documentation at least 5 times a week on an ongoing basis as indicated in question #3.</p> <p><u>Date of Compliance: January 14, 2012</u></p>		