

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2014
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NAME OF PROVIDER OR SUPPLIER LINTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN 47441
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an extended survey - immediate jeopardy.</p> <p>Survey date: May 12, 2014 Extended dates: May 13, 14, 15, & 16, 2014</p> <p>Facility number: 000333 Provider number: 155414 AIM number: 100288370</p> <p>Survey team: Diana McDonald, RN-TC Melissa Gillis, RN (May 12, 13, 14, & 15, 2014) Cheryl Mabry, RN (May 13, 15, & 16, 2014) Angela Patterson, RN (May 12, 13, 15, & 16, 2014)</p> <p>Census bed type: SNF/NF: 31 Total: 31</p> <p>Census payor type: Medicare: 8 Medicaid: 17 Other: 6 Total: 31</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 15, 2014 to the annual licensure survey conducted on May 12, 2014 through May 16, 2014</p>	
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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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F000253 SS=E	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 26, 2014; by Kimberly Perigo, RN.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to maintain the residents' rooms in a orderly, comfortable, clean, and sanitary manner in that the rooms had dirty privacy curtains, closet doors not closing, wall paneling loose with an electrical outlet, water stained paneling, plastic parts loose on resident side of window, and hot water was at the maximum of 100 degrees after running for a minimum of ten minutes. This deficient practice effected 10 out of 18 rooms. (Resident's #8, #12, #15, #16, #18, #21, #23, #26, #31, & #49)</p> <p>Findings include:</p> <p>Observation on 5/16/14 at 1:30 p.m., in room</p>	F000253	<p>F253</p> <p>It is the practice of this facility to provide housekeeping services to assure a comfortable and sanitary environment is provided for the residents.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Residents #8, #12, #15, #16, #18, #21, #23, #26, #31, and #49 have been addressed as indicated by the correlating room numbers and specific corrections below.</p> <p>Privacy curtains have been removed and cleaned in rooms/bed#1B, 4A, 5A, 6A, 7B, 11C, 14B, 15A, and 18A.</p> <p>The closet doors have been adjusted and now close in rooms/bed# 4A, 5A, 6A, 16A, and 18A.</p> <p>Room/bed# 11C ceiling has been</p>	06/15/2014			

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	<p>6A , the privacy curtains were dirty and the closet doors did not close.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 1B, the privacy curtain at the foot of the bed had 2 brownish stains.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 15A, the privacy curtain at the foot of the bed had 2 brownish stains.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 18A, both of the privacy curtains had brown spots on them.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 11C, there were orange spots on the ceiling and the privacy curtains had brown stains all over them.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 14B, the privacy curtains were dirty with ink marks and brown stains.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 5A, the privacy curtains were dirty, and the closet door did not close.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 7B, the privacy curtains had brown stains.</p> <p>Observation on 5/16/14 at 1:30 p.m., in</p>		<p>cleaned</p> <p>The wall panel that contained the loose electrical outlet inroom/bed# 4A has been repaired.</p> <p>In room/bed# 10B, the paneling under the window has beenrepaired and the water stain corrected. The window ledge was cleaned and the plastic parts identified as comingfrom the window has been repaired. Thepaneling under the sink that was water stained has been corrected.</p> <p>The water temperature in the sink of 14B has been correctedand is reaching appropriate temperature in an timely manner.</p> <p>Other residents that have the potential to be affected havebeen identified by:</p> <p>Potentially all residents could be affected. All privacy curtains have been reviewed andif needed cleaned.</p> <p>All resident closet doors have been inspected and if neededrepaired.</p> <p>All rooms paneling has been reviewed for function andcleanliness and if needed repaired/corrected.</p> <p>All resident room windows have been reviewed for functioningand cleanliness and if needed repaired/corrected.</p> <p>Areas under resident sinks and above bed ceilings have beenreviewed and if needed repaired/corrected.</p> <p>Water temperatures are being reviewed and are meetingrequired temperatures in a timely manner.</p>				

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	<p>room 4A, the privacy curtains were dirty, the closet doors did not close, and the wall panel; which contained an electrical outlet; was loose.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 16A, the closet door did not close.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 18A, the closet door did not close.</p> <p>Observation on 5/16/14 at 1:30 p.m., in room 10B, the paneling under the window was broken and water stained. The window ledge was dirty, the window had plastic parts coming off the window, and the paneling under the sink was water stained.</p> <p>Observation on 5/13/14 at 1:17 p.m., in room 14B, the water temperature at the sink reached 100 degrees Fahrenheit after waiting 10 minutes.</p> <p>Interview with maintenance man on 5/13/14 at 1:18 p.m., in room 14B, indicated after 10 minutes the water temperature finally reached 100.00 degrees. Having further indicated when the resident needs hot water the resident must go to another room. The facility has been aware of hot water problem for some time.</p>		<p>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been scheduled for Housekeeping to assure they understand the cleaning schedule including the cleaning of ceilings, window ledges, and paneling where water stains may occur. The in-service for Housekeeping also covers observing the cubicle curtains when daily cleaning the room and if dirt/stains are noted that they are to be immediately addressed. Maintenance has been in-serviced related to assuring that wall panels are secure, windows are functioning properly and in good repair, closet doors secure appropriately, and that water temperatures are tested and meet required temperatures in a timely manner. Administration will be making weekly rounds to assure areas in housekeeping and maintenance meet the required guidelines.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement tool has been initiated that randomly reviews 5 resident rooms for cleanliness and proper maintenance repair. The tool observes for water stains, privacy curtains cleanliness, ceiling cleanliness, broken paneling, closet</p>		

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F000279 SS=D	<p>3.1 -19(f)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10,</p>		<p>door functioning, window arefunctioning and cleanliness, and water temperatures. The Maintenance Director/HousekeepingSupervisor, or designee, will complete this tool weekly x3, monthly x 3, andquarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will reviewthe tools at the regularly scheduled meetings with recommendations for newinterventions as needed based on the outcomes of the tools.</p> <p>The date the systemic changes will be completed: June 15, 2014</p>		

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	<p>including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure a careplan was developed and interventions were implemented for a resident who had an identified pressure ulcer on 2 separate admission assessments for 1 of 5 residents who met the criteria for review of pressure ulcer. (Resident #21)</p> <p>Findings include:</p> <p>On 5/15/2014 at 2:56 p.m., the clinical record was reviewed for Resident #21. The diagnoses included, but were not limited to: sepsis, hypoxia, dehydration, anemia, urinary retention, diverticulitis, end stage renal disease, and coronary artery disease.</p> <p>The admission MDS (Minimum Data Set) assessment dated 3/12/2014, assessed Resident #21 as at risk for pressure ulcer. The assessment indicated Resident #21 had no pressure ulcer. The bowel and bladder assessment, assessed his bladder function as frequently incontinent (7 or more episodes of incontinence) and bowel function as frequently continent.</p>	F000279	<p>F279</p> <p>It is the practice of this facility to assure that the residents' careplans are developed and address the needs identified by the comprehensive assessment.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident #21 no longer resides in the facility. This resident has passed away.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents have been reviewed to assure that the plan of care addresses pertinent information related to the residents' current status.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been conducted for nurses related to assuring that changes in a resident status including skin issues and/or incontinence issues are identified/updated on the plan of care. The IDT team which meets each business morning will also be reviewing new admissions, new orders, and changes in the resident's condition and will also assure that the care plan has been updated properly. This would include assuring that new admissions</p>	06/15/2014			

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	<p>On 5/15/2014 at 4:20 p.m., the DoN (Director of Nursing) provided the "ADMISSION NURSING ASSESSMENT" dated 3/5/2014, for Resident #21. The assessment indicated the Braden Pressure Ulcer Risk Score (a tool used to identify if a Resident is at risk for obtaining a pressure ulcer). A score of 9 or less represents severe risk, a score of 10-12 represents high risk, a score of 15-18 represents a mild risk. Resident #21's score was an 18. This score indicated he was at mild risk for obtaining a pressure ulcer. The General Skin Condition part of the form indicated Resident #21 had a, "reddened area blanchable [an area that when pressed will turn white and then return to normal color, indicated the tissue is receiving blood flow]." The assessment for bowel and bladder indicated Resident #21 was continent of bowel and bladder. The assessment was signed, as accurate, by LPN #3.</p> <p>On 5/15/2014 at 4:20 p.m., the DoN (Director of Nursing) provided the facilities "SKILLED DAILY NURSES NOTE" dated 4/17/2014. The nurses note indicated briefs/pads utilized. A hand written noted for 7:00 p.m., indicated "...Cont [continent] of B/B [bowel and bladder]....Skin w/d [warm & dry] pale.... Signed as accurate, by</p>		<p>with skin areas and/or new skin issues are addressed appropriately on the plan of care with appropriate interventions.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to the care plan accurately reflecting the resident's condition related to skin condition and/or incontinence status. It also reviews to assure that identified changes have been updated on the care plan if they occur. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p>The date the systemic changes will be completed: June 15, 2014</p>				

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	<p>LPN #7.</p> <p>The MDS (Minimum Data Set) assessment, dated 4/18/2014, assessed, Resident #21 as having no pressure ulcers and the at risk for pressure ulcers was not assessed. The bowel and bladder assessment, assessed Resident #21 as frequently incontinent of bladder and frequently continent of bowel.</p> <p>On 5/15/2014 at 3:37 p.m., a physicians order dated 4/18/2014 at 4:20 p.m., was provided by LPN #3. The order indicated Resident #21 was transferred to the hospital for a direct admit. Resident #21 returned on 4/28/2014.</p> <p>On 5/15/2014 at 3:37 p.m., LPN #3 provided the facilities, "ADMISSION NURSING ASSESSMENT" for Resident #21 dated 4/28/2014. The assessment indicated the Braden Pressure Ulcer Risk Score. A score of 9 or less represents severe risk, a score of 10-12 represents high risk, a score of 15-18 represented a mild risk. Resident #21's score was a 19, which represented no risk. The general skin condition indicated he had a pressure ulcer to his coccyx (tailbone), not open sm (small) pressure ulcer. The assessment indicated Resident #21 was continent of bowel and bladder. The assessment was signed, as accurate, by</p>				

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	<p>RN #1.</p> <p>Review of the facilities "LINTON WEEKLY SKIN CONDITION REPORT" dated 5/5/2014 indicated Resident #21 was not identified as having a skin condition.</p> <p>Review of the facilities "LINTON WEEKLY SKIN CONDITION REPORT" dated 5/12/2014 indicated Resident #21 was not identified as having a skin condition.</p> <p>On 5/15/2014 at 3:32 p.m., an observation of Resident #21's buttocks with LPN #3 indicated an area the size of a grapefruit over the tailbone. The area was red and the innermost area over the coccyx the size of a nickel was non-blanchable (when the skin is pressed there is no change in the color, indicating decreased blood flow to the area). Within this area 2 very small areas where the skin was peeling was identified. Resident #21 was wearing a disposable brief, no creams or dressing on the area identified.</p> <p>On 5/16/2014 at 10:40 a.m., an observation of Resident #21's pressure ulcer with the Wound Care Nurse and DoN indicated his pressure ulcer was a stage 1 size of a grapefruit, with the</p>						

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F000309 SS=E	<p>innermost area on the coccyx the size of a nickel was not blanchable, there were two very small superficial areas where the skin was peeling. The "house" cream (a cream to protect an area from moisture) was applied to the area by the Wound Care Nurse.</p> <p>The Taber's Cyclopedic Medical Dictionary, 22nd edition, copyright 2013, defined a pressure ulcer as: "Damage to the skin or underlying structures from compression of tissue and inadequate perfusion....nursing home residents are all at risk. Some evidence also suggest that incontinence is a risk factor."</p> <p>On 5/15/2014 at 3:55 p.m., the care plan was provided by LPN #1. No Care plan related to pressure ulcers, skin integrity, nor incontinence had been implemented for Resident #21.</p> <p>On 5/15/2014, asked for policy and procedures related to care plan. No policy or procedures related to skin care or pressure ulcers were provided.</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p>						

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	<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>1. Based on observation, interview, and record review, the facility failed to ensure physician orders were transcribed accurately to ensure quick acting insulin was listed on the medication administration record accurately and available in the medication cart for the resident to receive, when the blood sugar measure required treatment as the physician order indicated. (Resident #32).</p> <p>Findings include:</p> <p>On 5/15/2014 at 9:17 a.m., the clinical record was reviewed for Resident #32. Diagnoses included, but were not limited to Alzheimer's, hypertension, depression, dementia with delusions, seizures, and diabetes mellitus.</p> <p>Medications (physician orders May 2014) included, but were not limited to: Lantus 20 units subcutaneous (injection beneath the skin) at bedtime (a long acting insulin for the treatment of diabetes mellitus type 1). Accucheck every 6 hours with sliding scale. No short acting insulin ordered for</p>	F000309	<p>F309 It is the practice of this facility to assure that the all residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment. The correction action taken for those residents found to be affected by the deficient practice include: Resident #32 has been reviewed. The resident currently has a physician's order for short-acting insulin to correlate with the sliding scale blood sugars. The insulin is being sent from the pharmacy specifically for the resident. Other residents that have the potential to be affected have been identified by: All diabetic residents have been reviewed to assure that if the resident is to be on sliding scale insulin that the insulin order is present to correlate with the sliding scale and that the insulin is available for the resident to be administered in correlation with the order The measures or systematic changes that have been put into place to ensure that the deficient practice does</p>	06/15/2014			

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	<p>sliding scale. (short acting insulin is used to control elevated blood sugars).</p> <p>The quarterly MDS (Minimum Data Set) assessment dated 1/22/1014, assessed Resident #32's BIMS (Brief Interview for Mental Status) as not able to complete interview, and received a score of 0. This score indicated the resident was not interviewable.</p> <p>On 5/15/2014 at 10:15 a.m., an interview with LPN #3 indicated Resident #32 received NovoLog (fast acting insulin) for her sliding scale insulin (a scale used to determine how much insulin a resident receives when their blood sugar is elevated).</p> <p>On 5/15/2014 at 10:17 a.m., LPN #3 reviewed the medication administration record for Resident #32. At that time, an interview with LPN #3 indicated there is no insulin ordered for her sliding scale. LPN #3 indicated she didn't know what insulin Resident #32 had received for her slicing scale.</p> <p>On 5/15/2014 at 10:20 a.m., an observation of Medication Cart A indicated there was no sliding scale insulin in the medication cart for Resident #32. When asked what insulin Resident #32 had been receiving for the</p>		<p>not recur include: Nurses have been in-services related to assuring that residents receive insulin in correlation with the physician's order. The in-service also addresses that if a resident receives an order for a sliding scale insulin, that the order must be transcribed appropriately to include the specific insulin to be administered based on the blood sugar levels. The IDT team meets each business morning and will review all physician orders. Any resident identified to have a new order related to insulin or sliding scale will be reviewed further to assure that the order was transcribed accurately and that if sliding scale is ordered that there is a specific short-acting insulin order to correlate. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to review residents related to blood sugars, diabetic orders, and insulin administration. The tool will randomly review 5 residents to assure orders are appropriate and complete, and that documentation identifies that the resident is receiving insulin in accordance with the physician's order. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be</p>				

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	<p>sliding scale, LPN #3 indicated she did not know.</p> <p>On 5/15/2014 at 10:35 a.m., an interview with the pharmacist indicated Resident #32 did not have fast acting insulin ordered to go with the blood sugar checks, that were ordered every 6 hours.</p> <p>On 5/15/2014 at 10:44 a.m., an interview with LPN #1 indicated she has given Resident #32 sliding scale insulin, but doesn't remember what she gave. She indicated the medication administration records received by the pharmacy are checked off every month by a nurse and the nurse signs off on the medication sheets that they are accurate.</p> <p>On 5/15/2014 at 11:25 a.m., the Administrator provided the facilities "MEDICATION ADMINISTRATION RECORD" dated 3/1/2014-3/31/2014, and was signed by LPN #5 on 2/27/2014, as accurate. The Medication Administration Record (MAR) indicated a physicians order dated 4/29/2013, the order indicated: "Accuchecks [a finger stick to determine blood sugar level] every 6 HRS [hours] >69 call DR [physician] 151-200 = 3 units 201-250 = 5 units 251-300 = 7 units</p>		<p>immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tools with recommendations as needed based on the outcome of the tools. The date the systemic changes will be completed: June 15, 2014</p>				

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	<p>301-350 = 9 units 351-400 = 11 units 401-999 = Notify MD [physician]". No fast acting insulin for use with the sliding scale was identified on the MAR.</p> <p>On 5/15/2014 at 11:25 a.m., the Administrator provided the facilities "DIABETIC MONITORING FLOWSHEET" date March 2014. The flowsheet indicated Resident #32's blood sugar was elevated and received insulin on: 3/21 at 4:00 p.m., blood sugar was 194 and received 3 units. No insulin identified 3/29 at 4:30 p.m., blood sugar was 161 and received 3 units of Humalog (LPN #8) 3/30 at 6:00 a.m., blood sugar was 172 and received 3 units of Humalog (LPN #7) 3/30 at 11:30 a.m., blood sugar was 155 and received 3 units of Humalog(LPN #7) 3/31 at 5:00 p.m., blood sugar was 182 and received 3 units. No insulin identified. (No signature available) No site of injection identified on the facilities "DIABETIC MONITORING FLOWSHEET."</p> <p>On 5/15/2014 at 11:25 a.m., the Administrator provided the facilities</p>				

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	<p>"MEDICATION ADMINISTRATION RECORD" dated 4/1/2014-4/30/2014, and signed by LPN #5 on 3/31/2014, as accurate. The Medication Administration Record (MAR) indicated a physicians order dated 4/29/2013, the order indicated:</p> <p>"Accuchecks [a finger stick to determine blood sugar level] every 6 HRS [hours] >69 call DR [physician] 151-200 = 3 units 201-250 = 5 units 251-300 = 7 units 301-350 = 9 units 351-400 = 11 units 401-999 = Notify MD [physician]". No fast acting insulin for use with the sliding scale was identified on the MAR.</p> <p>On 5/15/2014 at 11:25 a.m., the Administrator provided the facilities "DIABETIC MONITORING FLOW SHEET" dated April 2014. The flowsheet indicated Resident #32 received: On 4/7/2014 at 11:00 a.m., she received 3 units in her abdomen for a blood sugar of 157. (LPN #7) On 4/2/2014 at 11:00 a.m., she received no insulin for a blood sugar of 178. (LPN #2) On 4/2/2014 at 4:00 p.m., she received no insulin for a blood sugar of 164 (LPN #2)</p>						

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	<p>On 4/11/2014 at 12:00 a.m., she received 3 units for a blood sugar of 162. (LPN #6)</p> <p>On 4/12/14 at 12:05 a.m., she received no insulin for a blood sugar of 173. (LPN #7)</p> <p>On 4/13/2014 at 6:00 a.m., she received 3 units for a blood sugar of 152.</p> <p>On 4/13/2014 at 11:00 a.m., she received 5 units for a blood sugar of 201.</p> <p>On 4/13/2014 at 4:00 p.m., she received 3 units for a blood sugar of 157.</p> <p>On 4/14/2014 at 4:00 p.m., she received 3 units for a blood sugar of 158.</p> <p>On 4/19/2014 at 11:30 a.m., she received 3 units for a blood sugar of 157.</p> <p>On 4/20/2014 at 11:30 a.m., she received 3 units for a blood sugar of 162.</p> <p>On 4/23/2014 at 4:00 p.m., she received 3 units for a blood sugar of 171.</p> <p>On 4/27/2014 at 11:00 a.m., she received 0 units for a blood sugar of 157. (LPN #8)</p> <p>The insulin used was not indicated on the flowsheet by nursing.</p> <p>On 5/15/2014 at 9:00 a.m., asked for the pharmacy delivery sheets for Resident #32 for the last 90 days.</p> <p>On 5/15/2014 at 10:55 a.m., the facilities pharmacy "CONSOLIDATED DELIVERY SHEETS" was provided by LPN #3. Was given pharmacy delivery</p>				

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	<p>sheets dating from 4/28/2014 to 5/13/2014. No short/fast acting insulin was delivered from the pharmacy for Resident #32.</p> <p>On 5/15/2014 at 10:53 a.m., a pharmacy communication titled "Phone Order" indicated Resident #32's "Clarification of previous order-Humalog insulin clarified to be continued as drug previously ordered for sliding scale use on 4/29/2013 and has not been D/C'd [discontinued] to date."</p> <p>On 5/15/2014 at 2:00 p.m., an interview with DoN indicated the staff have been pulling the HumaLog out of the emergency drug kit. When asked for copies of emergency drug kit (EDK) slips she indicated she doesn't keep them.</p> <p>On 5/15/2014 at 2:15 p.m., LPN #3 provided the emergency drug kit forms that the facility uses when pulling medications from the emergency drug kit when medications are not available on the medication cart. At that time, an interview with her indicated these were all the EDK forms the facility filled out since July 2013 until May 15 2014. The emergency drug kit form, from the pharmacy indicated "...2. Yellow Copy - Must be kept in the facility for record of disposition per Board of Pharmacy</p>						

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	<p>regulation..." There were 7 forms for Resident #32, the forms were dated between 2/20/2014-2/24/2014 and indicated the facility had removed an antibiotic for a urinary tract infection all 7 times. No form for removal of Humalog for Resident #32.</p> <p>On 5/15/2014, at 10:30 a.m., an interview with the DoN indicated she called the physician and he wanted Resident #32 to have Humalog (a fast acting insulin) for her sliding scale</p> <p>On 5/15/2014 at 2:31 p.m., an interview with the DoN indicated she was writing a clarification order for the Humalog for Resident #32, so that it would be fixed.</p> <p>On 5/16/2014 at 9:30 a.m., the DoN provided the clarification order for the Humalog to be used for the sliding scale for Resident #32.</p> <p>On 5/16/2014 at 9:40 a.m., review of the current months medication administration record indicated no insulin was identified to be used with the sliding scale. At that time, an interview with the DoN indicated she would right it in now.</p> <p>Asked for facility policy related to treatment of diabetic residents 3 times. No facility policy or procedure provided</p>			

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F000314 SS=D	<p>for monitoring and treating diabetic residents.</p> <p>3.1-37(a)</p> <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, interview, and record review, the facility failed to ensure a resident received treatment for a pressure ulcer in that a pressure ulcer was identified on 2 separate admission assessments and the resident did not receive treatment for 1 of 5 residents who met the criteria for review of pressure ulcers. (Resident #21).</p> <p>Findings include:</p> <p>On 5/15/2014 at 2:56 p.m., the clinical record was reviewed for Resident #21. The diagnoses included but were not limited to: sepsis, hypoxia, dehydration, anemia, urinary retention, diverticulitis,</p>	F000314	<p>F314</p> <p>It is the practice of this facility to assure that the all residents receive the necessary care and services to prevent and treat pressure ulcers.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #21 no longer resides in the facility. This resident has passed away.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents that currently have skin conditions or are at high risk for skin breakdown have been reviewed to assure that proper treatments and services are in place to assist with the healing/prevention of wounds.</p>	06/15/2014			

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	<p>end stage renal disease, and coronary artery disease.</p> <p>On 5/15/2014 at 4:20 p.m., the DoN (Director of Nursing) provided the "ADMISSION NURSING ASSESSMENT" dated 3/5/2014, for Resident #21. The assessment indicated the Braden Pressure Ulcer Risk Score (a tool used to identify if a Resident is at risk for obtaining a pressure ulcer). A score of 9 or less represents severe risk, a score of 10-12 represents high risk, a score of 15-18 represents a mild risk. Resident #21's score was an 18, which represented a mild risk for obtaining a pressure ulcer. The General Skin Condition indicated a "reddened area blanchable [an area when pressed with change color and then return to its original color, indicated the tissue is receiving adequate blood flow]." The assessment for bowel and bladder indicated Resident #21 was continent of bowel and bladder. The assessment was signed, as accurate, by LPN #3.</p> <p>On 5/15/2014 at 4:20 p.m., the DoN (Director of Nursing) provided the facilities "SKILLED DAILY NURSES NOTE" dated 4/17/2014. The nurses note indicated briefs/pads utilized. A hand written noted for 7:00 p.m., indicated "...Cont [continent] of B/B</p>		<p>The measures or systematic changes that have been put into place to ensure that the deficient practicedoes not recur include: Nursing Staff has been in-serviced related to the prevention and/or of pressure ulcers. The in-service includes not only providing the actual treatment and accurate assessment of pressure ulcers, but also identifying those residents that either have a pressure ulcer or are at high risk of pressure ulcers to assure that appropriate interventions are in place to promote healing and/or prevent the development of pressure ulcers.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to observe for an accurate assessment related to risk of pressure ulcers, and will also review those residents with identified skin issues to assure that there is a treatment order and it is identified on the TAR. The tool will randomly review 5 residents to assure that proper interventions are in place related to the preventions and/or treatment of pressure ulcers. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at</p>				

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	<p>[bowel and bladder]....Skin w/d [warm &dry] pale...."</p> <p>On 5/15/2014 at 3:37 p.m., a physicians order dated 4/18/2014 at 4:20 p.m., was provided by LPN #3. The order indicated Resident #21 was transferred to the hospital for a direct admit. Resident #21 returned on 4/28/2014.</p> <p>On 5/15/2014 at 3:37 p.m., LPN #3 provided the facilities "ADMISSION NURSING ASSESSMENT" for Resident #21 dated 4/28/2014. The assessment indicated the Braden Pressure Ulcer Risk Score). A score of 9 or less represents severe risk, a score of 10-12 represents high risk, a score of 15-18 represents a mild risk. Resident #21's score was a 19, which represented no risk. The general skin condition indicated he has a pressure ulcer to his coccyx (tailbone) not open sm (small) pressure ulcer. The assessment indicated Resident #21 was continent of bowel and bladder. The assessment was signed, as accurate, by RN #1.</p> <p>On 5/15/2014 at 3:55 p.m., the care plan was provided by LPN #1. No Care plan related to pressure ulcer, or skin integrity for Resident #21.</p> <p>Review of the facilities "LINTON</p>		<p>the scheduled meeting following the completion of the tools with recommendations as needed based on the outcome of the tools..</p> <p>The date the systemic changes will be completed: June 15, 2014</p>				

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	<p>WEEKLY SKIN CONDITION REPORT" dated 5/5/2014, indicated Resident #21 was not identified as having a skin condition.</p> <p>Review of the facilities "LINTON WEEKLY SKIN CONDITION REPORT" dated 5/12/2014, indicated Resident #21 was not identified as having a skin condition.</p> <p>On 5/15/2014 at 3:32 p.m., an observation of Resident #21's buttocks with LPN #3 indicated an area the size of a grapefruit around the tailbone. The area was red and the innermost area over the coccyx, the size of a nickel was non-blanchable (an area when pressed has no change in color, indicating the tissue is not receiving adequate blood flow) within this area 2 very small areas where the skin was peeling was identified. Resident #21 was wearing a disposable brief, no creams or dressing on the area identified.</p> <p>On 5/15/2014 at 3:40 p.m., an observation of the treatment sheets indicated no treatments for Resident #21. At that time, an observation of the treatment cart indicated no treatments present for Resident #21. At that time, an interview with LPN #3 indicated there wasn't.</p>						

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	<p>On 5/15/2014 at 3:45 p.m., an interview with LPN #3 indicated the Braden Scale dated 3/5/2014 and 4/28/2014, was wrong for Resident #21. At that time, she indicated she would redo the Braden Scale for Resident #21, and contact the Wound Nurse to assess his pressure ulcer.</p> <p>On 5/16/2014 at 9:20 a.m., an observation of the treatment sheets for Resident #21 indicated there was no treatment for the pressure ulcer. Review of the Braden scale indicated no new Braden Scale for Resident #21. At that time, an interview with DoN indicated she was unaware Resident #21 had a pressure ulcer and would contact the Wound Care Nurse to assess the pressure ulcer. No physicians order for any skin treatment related to the pressure ulcer identified.</p> <p>On 5/16/2014 at 10:00 a.m., an interview with the Wound Nurse indicated she was unaware that Resident #21 had a pressure ulcer. At that time, she indicated she already treated his pressure ulcer with the house cream until she hears back from the physician.</p> <p>On 5/16/2014 at 10:40 a.m., an observation of Resident #21's pressure</p>			
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F000323 SS=J	<p>ulcer with the Wound Care Nurse and DoN indicated his pressure ulcer was a stage 1, was the size of a grapefruit. With the innermost area on the coccyx the size of a nickel was not blanchable. There were two very small superficial areas where the skin was peeling. The "house" cream (a cream used to protect the skin from moisture) was applied to the area by the Wound Care Nurse.</p> <p>3.1-40(a)(2)</p> <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, interview, and record review, the facility failed to provide adequate supervision to prevent an elopement for 1 of 3 and 3 extended residents reviewed for elopement in that the facility failed to monitor an elopement risk resident as indicated by their care plan, which resulted in the resident having eloped. (Resident # 49)</p>	F000323	<p>F323 It is the practice of this facility to assure that residents that are identified as being at risk for elopement have appropriate interventions in place to assure their safety.</p>	06/15/2014			

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	<p>The immediate jeopardy began on 5/13/2014, when Resident #49 had been assessed as an elopement risk, with a care plan in place to monitor to prevent elopement, and a system had not been implemented to monitor to prevent elopement; which occurred on 5/13/2014 at 4:00 p.m. The Administrator and Director of Nursing were informed of the immediate jeopardy on 5/13/2014 at 5:10 p.m.</p> <p>The immediate jeopardy that began on 5/13/2014 was removed on 5/14/2014 when the facility implemented an abatement plan which indicated, "... it will reassess all residents related to elopement risk. Any resident identified to be at risk for elopement will have a care plan implemented, be identified on the CNA assignment sheet, and be placed in the Elopement Book that has identifying descriptive information for the resident. A company will be installing a Wander-Guard system that will address any resident that are at risk of elopement. Two of the doors will have the system installed beginning on 5-13-14. The equipment on the third door will be available for installation by 5-14-14... All staff will be in-serviced related to the new system implementation and protocol related to residents</p>		<p>The corrective action taken for those residents found to be affected by the deficient practice includes: Resident #49 has a wanderguard bracelet in place at this time.</p> <p>Other residents that have the potential to be affected have been identified by: All residents have been assessed related to elopement risk. If the resident is identified to be at risk of elopement, appropriate interventions have been implemented. This included residents #9, #25, #32, #39, and #48.</p> <p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: All residents will be assessed for elopement risk at the time of admission, with a significant change, and quarterly thereafter. Any resident identified as being at risk for elopement will have appropriate interventions implemented including the wanderguard bracelet. These</p>	
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	<p>identified to be at risk for elopement. That task will be completed by 5-14-14. Any personnel not attending the training on this day will have to receive the training before they are allowed to work a schedule shift..." The noncompliance remained at the lower scope and severity of potential for elopement risk of 6 residents who reside at the nursing facility due to the facility had not yet fully implemented the systemic abatement plan dated 5/14/2014. (Resident #49, #25, #48, #32, #39, and #9)</p> <p>Findings include:</p> <p>Observation on 5/13/2014 at 4:00 p.m., Resident #49 was observed to exit from the facility, via a side door across from the nurses station. A visitor was entering the facility, Resident #49 walked past the visitor while the door was opened, and exited the facility unobserved by staff. LPN #1 was sitting at the nurses station. LPN #1 was looking down at the desk charting in residents' records. The maintenance man was standing in front of the nurses station, with his back toward the exit door. Surveyor notified staff Resident #49 had exited the building. Maintenance man came to the door, talked with the resident who was standing outside the building, to get him to come</p>		<p>interventions will be identified on the plan of care. In addition, any resident that is at risk for elopement will have descriptive information placed in the Elopement book.</p> <p>A new wander-guard system was installed prior to the exit of the surveyors. The system was installed on all 3 of the facility exit doors. This alarm system will be the primary alarm system as it is the only alarm system that is connected to the doors. All staff has been in-serviced on the protocol related to elopement and the functioning of the new system.</p> <p>The correction action taken to monitor Performance to assure compliance Through quality assurance is: A Performance Improvement tool was initiated that will randomly review 5 residents that are identified as being at risk for elopement. The tool will audit for the assessment, the care plan, the CNA assignment sheet, and ensure that appropriate interventions are in place. The Director of Nursing, or designee, is</p>	

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	<p>back inside. LPN #1 helped Resident #49 back inside the building.</p> <p>Resident #49 exited the building using the side door to the build. Observation of the outside area to the side exit door indicated the door opens directly into the only parking lot for the building. Cars drive closest to the building to part angular on the outside of the parking area. The entrance for the parking is on route to State Road 54, which is approximately 75 feet from the side exit of the building.</p> <p>Resident #49's clinical recorded was reviewed on 5/13/2014 at 4:25 p.m. Diagnoses included, but not limited to, Alzheimer's disease.</p> <p>An Administrator Record form indicated an admission date of 2/9/2014.</p> <p>An Elopement Risk Assessment dated 2/13/2014, indicated a score of 21 (a score of 5 or more is considered to be at risk for elopement), in regard to identified risks of cognitive impairment, Alzheimer's diagnosis, independently ambulatory, difficulty accepting placement, history of elopement, wanders aimlessly, verbally expresses a desire to go home, expresses a desire to locate a family member, and has been observed to</p>		<p>responsible for the completion of the audit. This tool will be completed weekly x3, monthly x3, and quarterly x3. Anyidentified issues will be immediately corrected. The tools will be reviewed at the scheduled Quality Assurance Meetings with recommendations as needed based on the findings of the tools.</p> <p><i>The date the systemic changes will be Completed:</i></p> <p>May 14, 2014</p>				

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	<p>stand at the exit door waiting for someone to let him out.</p> <p>The current Minimum Data Set Assessment dated 4/11/2014 indicated a Brief Interview of Mental Status (BIMS) score of 3, which indicated Resident #49 had severe cognitive impairment and was dependent on nursing staff for daily decision making. Resident #49 independently ambulated in his room and facility halls, with staff supervision.</p> <p>Resident #49's care plan dated 2/13/2014, and remained current at time of survey, titled Elopement Risk/Exit Seeking indicated Resident #49 exhibits exit -seeking behavior as evidence by: 1. standing at doors, 2. asking for ride home, 3. looking for wife. Goal for behavior, "Resident will not successfully elope the facility and will be monitored of their whereabouts on an ongoing basis through next review date: 5/13/14." Approach "Monitor resident for 'tailgating' when visitors are in the building."</p> <p>Review of nursing notes indicated the following: 2/11/2014 7:00 p.m. - 7:00 a.m., "Res [Resident] has been walking around facility most of noc [night], some confusion as to where his room is."</p>			

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	2/17/2014 7:00 a.m. - 7:00 p.m., "...wife visited today; keeps wanting her to bring car back so he can leave. ... Very independent; walks c [with] cane."			
	2/25/2014 7:00 p.m. - 7:00 a.m., "... wanders aimlessly, almost seems 'lost' ..."			
	3/27/2014 7:00 p.m. - 7:00 a.m., "... wanders unable to find room..."			
	4/3/2014 7:00 p.m. - 7:00 a.m., "... up and down most of the night...appears 'lost'. Needs frequent cueing and direction ..."			
	4/6/2014 7:00 p.m. - 7:00 a.m., "... up and down most of night...wandering the hall aimlessly. Appears 'lost'. Needs frequent cueing and direction..."			
	4/16/2014 7:00 p.m. - 7:00 a.m., "... Wanders hallways when up. Was trying to get out side door earlier in shift redirected @ that x [time]. ..."			
	5/8/2014 7:00 p.m. - 7:00 a.m., "Wkly [Weekly] Summary...disoriented x [time] et [and] place up ad lib [at will] ... decision making ability poor, res was in et out of several rooms earlier in the shift... wanders a lot..."			

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	<p>5/12/2014 no time documented, "... wanders throughout facility..."</p> <p>On 5/13/2014 at 4:25 p.m., the Administrator provided a copy of the facility elopement policy non dated, and indicated the policy was currently used by the facility. Review of the policy indicated, "...It is the policy of this facility to assess all residents upon admission to the facility and quarterly for their risk of elopement. Residents who are assessed as being high risk for elopement will have a plan of care that identifies the risk and appropriate interventions. A picture of the resident with relocation information shall be placed in the Elopement Risk Book kept at the nurses station."</p> <p>Social Service progress note dated 5/13/2014 (no time documented) indicated, "Res was standing at side door and was looking for his wife who picks him up dly [daily] after she gets off work and takes him for a drive and to get ice cream. A family member [not resident's] came in side door and before it [exit door] latched the res pushed on the door & proceeded to hold on to handle and look on out facility door. State surveyor alerted this writer that he was at the door and starting to walk out it. The</p>			

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	<p>Maintenance Man & this writer went immediately to the door & when I turned around c [with] res Nurse was right beside me. ..."</p> <p>Interview with the DON on 5/13/2014 at 4:17 p.m., indicated; when asked if the facility had a monitoring system in place to prevent elopement; "No."</p> <p>On 5/14/15 the Administrator provided elopement risk assessments dated 5/13/14, for residents who resided at the nursing facility. A review of the assessments indicated the following:</p> <p>2. Resident #25: Diagnoses included, but were limited to dementia and Alzheimer's. A BIMS score of 0 dated 3/10/2014, which indicated not interviewable. An elopement risk score of 17, which indicated high risk for elopement. A car plan for elopement dated 5/13/2014, with implementation of wander guard bracelet.</p> <p>3. Resident #48: Diagnoses included, but were not limited to Alzheimer's. A BIMS score of 11 dated 3/29/2014, which indicated moderate cognitive impairment. An elopement risk score of 10, which indicated high risk for elopement. A care plan for elopement dated 5/13/2014, with implementation of wander guard bracelet..</p>				

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	<p>4. Resident #32: Diagnoses included, but were not limited to dementia and Alzheimer's. A BIMS score of 0 dated 1/22/2014, which indicated not interviewable. An elopement risk score of 17, which indicated high risk for elopement. A care plan for elopement dated 5/13/2014, with implementation of wander guard bracelet.</p> <p>5. Resident #39: Diagnoses included, but were not limited to dementia and Alzheimer's. A BIMS score of 1 dated 3/13/2014, which indicated severe cognitive impairment and dependent on nursing staff for daily decision making. An elopement risk score of 23, which indicated high risk for elopement. A care plan for elopement dated 5/13/2014, with implementation of wander guard bracelet.</p> <p>6. Resident #9: Diagnoses included, but were not limited to dementia and Alzheimer's. A BIMS score of 3 dated 4/9/2014, which indicated severe cognitive impairment and dependent on nursing staff for daily decision making. An elopement risk score of 21, which indicated high risk for elopement. A care plan for elopement dated 5/13/2014, with implementation of a wander guard bracelet.</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue</p>			

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	<p>these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was free from unnecessary medications as a medication was given without a diagnosis, and a antipsychotic medication was given without documentation of required attempts for a gradual dose reduction for 1 of 5 residents reviewed for unnecessary medication use. (Resident #32)</p> <p>Findings include:</p> <p>On 5/15/2014 at 9:17 a.m., the clinical record was reviewed for Resident #32. Diagnoses included, but were not limited to Alzheimer's, hypertension, depression, dementia with delusions, seizures.</p> <p>Medications included but were not limited to risperidone 0.5 mg tablet at bedtime for dementia with illusions. furosemide 40 mg daily (no diagnosis given for the use of furosemide).</p> <p>The quarterly MDS (Minimum Data Set) assessment dated 1/22/1014, assessed Resident #32's BIMS (Brief Interview for Mental Status) as not able to complete interview, and received a score of 0. This score indicated the resident was not interviewable.</p>	F000329	<p>F329</p> <p>It is the practice of this facility to assure medications are administered based on the residents medical diagnosis and that request for reduction are submitted to the resident's physician in accordance with the regulation.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident #32 currently has a diagnosis for the use of Lasix. This resident, as identified in the 2567, has had a reduction in the psychotropic medication.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents that have been reviewed to assure that there is an appropriate diagnosis related to medication administration. In addition, all residents that receive psychotropic medications have been reviewed to assure that an attempt for reduction has been made in accordance with the regulation based on the determination of the physician.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>Nurses have been in-service related to assuring that when an order for a</p>	06/15/2014			

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	<p>1. A careplan for Resident #32 titled "Psychotropic Drug Use" for the use of risperidone dated 4/22/2014, indicated "Resident will be free from signs and symptoms of drug-related: Hypotension Gait disturbance cognitive impairment Behavioral impairment ADL decline Decline in appetite Abnormal involuntary movements through next review date. The Approach indicated: ...Monitor for effectiveness of psychotropic drugs and review for changes at psychotropic meeting, For antipsychotic medications - within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated such type of medication, under the direction of the pharmacist and/or physician, attempt a gradual dose reduction (GDR) in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR will be attempted annually, unless clinically contraindicated."</p> <p>The admission date at the facility for Resident #32 was 4/29/2013.</p>		<p>medication is received, that a correlating diagnosis is identified for the medications. The in-service also included assuring that residents that receive psychotropic medication are reviewed for possible reduction by the attending physician in accordance with the regulation. The consulting pharmacist will be working with the facility related to both of these areas on an ongoing basis.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that randomly reviews residents related to assuring that there is a diagnosis identified for the use of the medication. The tool will also review to assure that there is documentation that psychotropic reduction has been addressed in a timely manner with the physician. This tool will randomly review 5 residents. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools.</p> <p>The date the systemic changes will be completed: June 15, 2014</p>				

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	<p>On 5/16/2014 at 3:37 p.m., LPN #4 provided the GDR's for Resident #32 that was faxed from the pharmacy. On 10/23/2013, the pharmacy sent the facility a GDR for the use of Risperdal. The recommendation from the pharmacy was to decrease the Risperdal from 0.5 mg at HS (bedtime) to 0.25 mg at HS. There was no facility response given on the recommendation from the pharmacy.</p> <p>On 5/16/2014 at 3:15 p.m., an interview with the DoN indicated she no longer has the GDR (gradual dose reduction) from October 2013. Review of the GDR sent from the pharmacy indicated they provided the facility with a GDR to submit to the physician. The form indicated it was not accepted, no reason why indicated.</p> <p>On 5/16/2014 at 3:37 p.m., LPN #4 provided the GDR's for Resident #32. The GDR dated 5/16/2014 indicated, "CMS regulations require an attempt within the first year of admission on an antipsychotic medication,The reduction must be attempted twice within two separate quarters, with at least one month between attempts ...". The GDR indicated Resident #32 was receiving Risperdal 0.5 mg at HS (sleep). The recommendation was to change to 0.25 mg HS (sleep). The order was signed by</p>			

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	<p>the physician on 5/16/2014 agreeing to the GDR.</p> <p>The risperidone was started on 4/29/2013 and the reduction was completed on 5/16/2014 (after surveyor review).</p> <p>2. Review of the Medication Administration Record and physicians orders indicated Resident #32 had no diagnosis for the use of furosemide (a medication used to treat edema, excess fluid, and hypertension).</p> <p>On 5/15/2014 at 2:28 a.m., an interview with the DoN indicated the use of furosemide was for edema. When she reviewed the medication administration records, she confirmed there was no diagnosis for the use of the furosemide.</p> <p>On 5/16/2014 at 2:10 p.m., review of the physicians orders indicate no clarification order for the use of furosemide.</p> <p>On 5/16/2014 at 2:15 p.m., an interview with pharmacist indicated Resident #32 has a diagnosis of hypertension and the furosemide is used for hypertension. At that time, she indicated she had a message from the consulting pharmacist to include hypertension as a diagnosis for the use of furosemide.</p>						

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F000428 SS=D	<p>3.1-48(a)(4) 3.1-48(b)(2)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a pharmacist reported irregularities with a residents medication orders; in that a resident was receiving blood sugar checks and no fast acting insulin was on the medication administration records nor in the medication cart for the resident to receive, and that a diagnosis was indicated for the use of a medication on the medication administration records. This deficient practice had the potential to affect 1 of 5 residents reviewed for unnecessary medication use. (Resident #32).</p> <p>Findings include:</p> <p>On 5/15/2014 at 9:17 a.m., the clinical record was reviewed for Resident #32. Diagnosis included but were not limited</p>	F000428	<p>F428 It is the practice of this facility to assure that the consulting pharmacist addresses medication issues as part of the monthly reviews. The correction action taken for those residents found to be affected by the deficient practice include: Resident #32 has been reviewed. The resident currently has a physician's order for short- acting insulin to correlate with the sliding scale blood sugars. The insulin is being sent from the pharmacy specifically for the resident. The resident also currently has a diagnosis for the use of Lasix. Other residents that have the potential to be affected have been identified by: All residents that have been reviewed to assure that there is an appropriate diagnosis related to medication administration. All diabetic</p>	06/15/2014			

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	<p>to Alzheimer's, hypertension, depression, dementia with delusions, seizures.</p> <p>Medications included but were not limited to furosemide 40 mg tablet by mouth daily no diagnosis given Accucheck every 6 hours with sliding scale. No short/fast acting insulin (used to treat elevated blood sugar) ordered for sliding scale.</p> <p>The quarterly MDS (Minimum Data Set) assessment dated 1/22/1014, assessed Resident #32's BIMS (Brief Interview for Mental Status) as not able to complete interview, and received a score of 0. This score indicated the resident was not interviewable.</p> <p>On 5/15/2014 at 10:17 a.m., LPN #3 reviewed the medication orders for Resident #32. At that time an interview with LPN #3 indicated there is no insulin ordered for Resident #32's sliding scale. LPN #3 indicated she didn't know what insulin Resident #32 has been receiving for her sliding scale.</p> <p>On 5/15/2014 at 10:20 a.m., an observation of Medication Cart A indicated there was no sliding scale insulin in the cart for Resident #32. When asked what insulin Resident #32</p>		<p>residents have been reviewed to assure that if theresident is to be on sliding scale insulin that the insulin order is present tocorrelate with the sliding scale and that the insulin is available for theresident to be administered in correlation with the order The consultantpharmacist is visiting monthly with recommendations and identification of anyirregularities. The DON is following up on all pharmacy recommendationsat this time</p> <p>The measures or systematic changes that have been put into placeto ensure that the deficient practice does not recur include: Nurses have been in-serviced related to assuring that when an orderfor a medication is received, that a correlating diagnosis is identified forthe medications. In addition, Nurses have been in-services related to assuringthat residents receive insulin in correlation with the physician's order. The in-service also addresses that if a resident receives an order for asliding scale insulin, that the order must be transcribed appropriately toinclude the specific insulin to be administered based on the blood sugarlevels. The IDT team meets each business morning and will review allphysician orders. Any resident identified to have a new order related toinsulin or sliding scale will be reviewed further to assure that theorder was</p>				

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	<p>has been receiving, LPN #3 indicated she did not know.</p> <p>On 5/15/2014, at 10:30 a.m., an interview with the DoN indicated she called the physician and he wanted Resident #32 to have HumaLog sliding scale.</p> <p>On 5/15/2014 at 10:35 a.m., an interview with the pharmacist indicated Resident #32 did not have an order for sliding scale insulin to go with the Accucheck orders.</p> <p>On 5/15/2014 at 10:44 a.m., an interview with LPN #1 indicated she has given Resident #32 sliding scale insulin, but doesn't remember what she gave. She indicated the Medications are checked off every month by a nurse and the nurse signs off on the medication sheets.</p> <p>On 5/15/2014 at 9:00 a.m., asked for the pharmacy delivery sheets for Resident #32 for the last 90 days.</p> <p>On 5/15/2014 at 10:55 a.m., the facilities pharmacy "CONSOLIDATED DELIVERY SHEETS" was provided by LPN #3. Was given pharmacy delivery sheets dating from 4/28/2014 to 5/13/2014. No fast acting insulin was delivered from the pharmacy for Resident #32.</p>		<p>transcribed accurately and that if sliding scale is ordered that thereis a specific short-acting insulin order to correlate. The IDT will also assurethat any new order has a correlating diagnosis. The facility will bemeeting with the consultant pharmacist to review the findings in the survey toassure that during the monthly visits, these areas are reviewed closely. Thepharmacist will be reviewing monthly for irregularities and makingrecommendations as needed The consultant pharmacist visits monthly, reviewsmedications and makes recommendations. The pharmacist understandsthat any identified irregularities with recommendations should be identified onthe report. The DON will be getting a copy of the pharmacist consultantreport and will assure that all recommendations have been presented to thephysician with a timely response on the recommendations. Please see below formonitoring. The corrective action taken to monitorperformance to assure compliance through quality assurance is: A Performance Improvement tool has been established thatrandomly reviews residents related to assuring that there is a diagnosisidentified for the use of the medication. In addition, A PerformanceImprovement Tool</p>				

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	<p>On 5/15/2014 at 10:53 a.m., a pharmacy communication titled "Phone Order" indicated Resident #32's "Clarification of previous order-Humalog insulin clarified to be continued as drug previously ordered for sliding scale use on 4/29/2013 and has not been D/C'd (discontinued) to date."</p> <p>On 5/15/2014 at 2:00 p.m., an interview with DoN indicated the staff has been pulling the HumaLog out of the emergency drug kit. When asked for copies of emergency drug kit slips she indicated she doesn't keep them.</p> <p>On 5/15/2014 at 2:15 p.m., review of the emergency drug kit forms provided by LPN #3 and were dated from July 2013 until May 15 2014. The emergency drug kit form, from the pharmacy indicated "....2. Yellow Copy - Must be kept in the facility for record of disposition per Board of Pharmacy regulation...". There were 7 forms for Resident #32, the forms were dated between 2/20/2014-2/24/2014 and indicated they had removed an antibiotic for a urinary tract infection all 7 times. No form for removal of Humalog.</p> <p>From December 2013 until May 15, 2014, Resident #32 received insulin for</p>		<p>has been initiated that will be utilized to review residents related to blood sugars, diabetic orders, and insulin administration. The tool will randomly review 5 residents to assure orders are appropriate and complete, and that documentation identifies that the resident is receiving insulin in accordance with the physician's order. The PI tool will also review for timely follow-up on the pharmacy recommendations to assure that there is evidence of physician notification and response for each recommendation. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. The date the systemic changes will be completed: June 15, 2014</p>				

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	<p>the sliding scale blood sugar checks and there was no pharmacy delivery form or EDK removal form for Humalog that Resident #32 was to receive for the sliding scale when the blood sugar was elevated.</p> <p>2. Review of the Medication Administration Record indicated Resident #32 had no diagnosis for the use of furosemide (a medication used to treat edema, excess fluid, and hypertension).</p> <p>On 5/15/2014 at 2:28 a.m., an interview with the DoN indicated the use of furosemide was for edema (swelling from excess fluid). When she reviewed the medication administration records, she confirmed there was no diagnosis for the use of the furosemide.</p> <p>On 5/16/2014 at 2:10 p.m., review of the physicians orders indicated no clarification order for the use of furosemide.</p> <p>On 5/16/2014 at 2:15 p.m., an interview with pharmacist indicated Resident #32 has a diagnosis of hypertension and the furosemide is used for hypertension. At that time she indicated she had a message from the consulting pharmacist to include hypertension as a diagnosis for the use of furosemide.</p>						

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F000431 SS=C	<p>The irregularities had not been reported by the pharmacists after the monthly reviews, past 90 days.</p> <p>3.1-25(i)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>				

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	<p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that medications were stored properly as the facility policy indicated for 1 of 1 medication refrigerators and 1 of 2 medication carts (Medication cart B). This deficient practice had the potential to affect 31 of 31 residents residing in the facility. (Resident #39, Resident #48, Resident #15, Resident #50)</p> <p>Findings include:</p> <p>1. On 5/13/2014 at 1:00 p.m. an observation of the medication room indicated the thermometer in the medication room refrigerator temp was 60 degrees Fahrenheit. The thermometer positioned to the inside of the refrigerator door indicated it was 70 degrees Fahrenheit, according to the DoN. The inside of refrigerator was warm to the touch. The refrigerator contained expired medications consisting of 4 vials of of Hepatitis vaccine that was facility stock, 2 vials of influenza vaccine that was</p>	F000431	<p>F431</p> <p>It is the practice of this facility to assure that residents' medications are stored appropriately at proper temperature ranges for themedications and that medications are dated when opened as applicable anddisposed of based on the date of expiration in correlation with themanufacturer's guidelines. The correction action taken forthose residents found to be affected by the deficient practice include:</p> <p>A new refrigerator was purchased for the medicationroom. The Refrigerator is now atappropriate temperature for the storage of medications.</p> <p>The medications identified that were not dated or hadexceeded 28 days were disposed of properly during the survey process includingfor residents #39, #48, #15, and #50. New medications as well as new EDK were obtained from pharmacy.</p> <p>Other residents that have thepotential to be affected have been identified by:</p>	06/15/2014

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	<p>facility stock, 13 vials of Ativan for Resident #39, and an EDK (Emergency Drug Kit) in refrigerator was facility stock. At that time, an interview with the consulting pharmacist indicated these medications would have to be disposed of. He indicated he was just in the refrigerator and checked for expired meds, but did not notice the refrigerator was that warm.</p> <p>On 5/13/2014 at 1:00 p.m., an interview with the Consulting pharmacist indicated all the insulins in the refrigerator could be kept they would just have to be dated for today as the open date. At that time, he indicated the company the pharmacy uses for the Ativan recommends it only be kept for 24 hours when at room temperature. The pharmacist indicated the vaccines and EDK would have to be disposed of since the medications had reached room temperature.</p> <p>2. On 5/13/2014 at 12:20 p.m., an observation of the B Hall medication cart indicated the Magnesium Citrate dispensed on 4/15/14, for Resident #39 had no open date and Naphcon A drops had no open date and the dispense date was 7/24/13. At that time, LPN #2 indicated they should be disposed of.</p> <p>Resident #48's NovoLog 100u/ml vial</p>		<p>The Medication Refrigerator has been reviewed and is at the appropriate temperature for the storage of medications. All resident medications have been reviewed to assure that they are all dated as to when opened and are within the time limits of expiration in accordance with the manufacturer's guidelines.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>Nurses have been in-serviced related to the appropriate temperatures of the medication refrigerators. In addition, the in-service included dating certain medication such as eye drops and insulin when opened and assuring that they are only used within the expiration period per the manufacturer's guidelines. Nursing Administration will observe the temperature readings logs on the medication refrigerators as they make daily rounds as well as spot checking medications for dates and expirations. Please see below for systems for monitoring.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement tool has been established that reviews the medication refrigerator log to assure it is indicating acceptable</p>				

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	<p>dispensed on 3/11/14, no documented date opened. Vial had sticker that stated to discard unused portion after 28 days.</p> <p>Resident #15's NovoLog 100 u/ml vial dispensed on 4/9/2014 opened on 4/14/2014. At that time, an interview with LPN #2 indicated the NovoLog should be disposed of since it was past 28 days after opening.</p> <p>Resident #50's Mupirocin Ointment 2% dispensed on 10/25/13, container was open. At that time, an interview with LPN #2 indicated it should be disposed of since it was expired and the resident had been discharged from the facility.</p> <p>On 5/13/2014 at 2:50 p.m., the DoN provided the facilities "REFRIGERATOR TEMPERATURE LOG" for the medication room dated May 2014. The temperature log indicated from May 1-May 12th the temperature was below 41 degrees Fahrenheit.</p> <p>On 5/13/2014 at 4:17 p.m., the DoN provided the facilities undated policy titled "Storage of Medications". The policy indicated: "...2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean,</p>		<p>temperatures. In addition, this tool will review the medication refrigerators and medication carts to assure that medications have dates as to when opened and that they are not expired in accordance with the manufacturer's guidelines. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools.</p> <p>The date the systemic changes will be completed: June 15, 2014</p>				

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F000441 SS=D	<p>safe, and sanitary manner...</p> <p>4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed..."</p> <p>On 5/13/2014 at 1:00 p.m., the consulting pharmacist provided the pharmacies expiration dating policy, dated July 6, 2012, and indicated it was the current policy they use. The policy indicated: "...lorazepam injection (Ativan) can be kept for 24 hours at room temp...."</p> <p>3.1-25(m) 3.1-25(o)</p> <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;</p>						

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	<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 infection control practices were followed related to hand washing during patient wound care as indicated by the facility policy and procedure and the Center for Disease Control for 1 of 1 residents observed for pressure ulcer. (Resident #22) (C.N.A. #1 and LPN #1)</p> <p>Findings include:</p> <p>On 5/15/14 at 9:40 a.m., observed CNA #1 to enter Resident #22's room and</p>	F000441	<p>F441</p> <p>It is the practice of this facility to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident #22 now receives services including those related to dressing changes within acceptable parameters of infection control including proper handwashing.</p> <p>Other residents that have the potential to be affected have been</p>	06/15/2014

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	<p>handwashed for 7 seconds. CNA #1 was observed to place gloves on, walk over to Resident #22's recliner, remove the gloves, and exit the room. CNA #1 re-entered the room, handwashed for 7 seconds, put gloves on, and lifted Resident #22's left leg up for the dressing change. After the dressing change CNA #1 was observed to remove the gloves, handwash for 6 seconds, removed the trash bag, and exit the room.</p> <p>On 5/15/14 at 9:43 a.m., observed LPN #1 to enter Resident #22's room, handwashed for 5 seconds, removed a wound dressing from Resident #22's left heel, threw the dressing in the trash, handwashed for 5 seconds, prepared the supplies for the dressing change, put on gloves, and cleansed the wound. LPN #1 removed the gloves and placed on new gloves. There was no handwashing observed, at that time. LPN #1 applied skin prep, santyl, and placed the dressing on the wound. LPN #1 was observed to remove gloves and placed a footie on the Resident's left heel. No handwashing was observed. After placing the footie on Resident #22's foot, LPN #1 was observed to walk over to the sink and handwash for 7 seconds. LPN #1 was observed to remove the trash from the bedside table and exited the room.</p>		<p>identified by: All residents are receiving services within acceptable parameters of infection control including proper handwashing. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for nurses and CNAs related to proper infection control practices. The in-service addresses proper hand washing and proper changing of gloves. The facility will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents during provision of services including treatment changes related to following of proper infection control procedures during the provision of services. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. The tool will be completed randomly for all shifts in a 7 day period. Any issues identified will be immediately corrected and additional training will immediately</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			
	<p>On 5/15/14 at 10:20 a.m., the Administrator provided, "HANDWASHING" policy (undated) and indicated that was the policy currently used by the facility. The policy indicated, "... Handwashing should be performed: As promptly as possible after contact with blood, body fluids, secretions, excretions, ... whether or not gloves are worn. After gloves are removed, ... Before or after touching wounds and changing wound dressings. ... When indicated between tasks and procedures on the same resident to prevent cross contamination. ... PROCEDURE: ... 6. Lather all areas of the hands and wrists rubbing vigorously for 20 seconds. ..."</p> <p>On 5/9/14 review of the Centers for Disease Control and Prevention dated December 16, 2013, "Handwashing: Clean Hands Save Lives ... When and How to Wash Your Hands ... How should you wash your hands? Lather your hands by rubbing the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Need a time? Hum the 'Happy Birthday' song from beginning to end twice. Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them."</p>		<p>occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. The date the systemic changes will be completed: June 15, 2014</p>				

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

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OMB NO. 0938-0391

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