

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155436	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 29, 30, and 31, 2012 and September 4, 2012</p> <p>Facility Number: 000414 Provider number: 155436 AIM number: 100288550</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF/NF: 21 Total: 21</p> <p>Census Payor type: Medicare: 01 Medicaid: 17 Other: 03 Total: 21</p> <p>Sample: 10 Supplemental sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 9/07/12 by Suzanne Williams, RN</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Winamac desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 10/4/12.</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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F0157 SS=E	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's physician of a change in condition and medications being unavailable for 4 of 10 residents reviewed for physician</p>	F0157	F157 F157: Please describe what the facility did to correct the deficient practice for Resident #22. Please indicate if any in-services	10/04/2012			

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	<p>notification in a total sample of 10. (Residents #3, #6, #9, and #22)</p> <p>Findings include:</p> <p>1. Resident #22's record was reviewed on 08/31/12 at 12:20 p.m. The resident's diagnoses included, but were not limited to, spinal stenosis, non-Hodgkin lymphoma, and dementia.</p> <p>A) A Nurses' Note, dated 08/11/12 at 1:50 p.m., indicated, "Res (resident) sitting at table for breakfast eating-suddenly (sic) became dizzy and was not responding well to her name being called. Res taken to her room and laid down in bed. VS (vital signs) BP (blood pressure) 84/42...Stated the dizziness left and she felt better..."</p> <p>There was a lack of documentation to indicate the resident's physician had been notified of the incident.</p> <p>During an interview on 08/31/12 at 1:50 p.m., LPN #1 indicated she had not notified the physician, because the resident, "came out of it". She indicated this was not usual for the resident, so she just watched the resident.</p> <p>During an interview on 08/31/12 at 1:50 p.m., the DoN (Director of Nursing)</p>		<p>have been conducted. A note was entered on 10/3/12 that on 9/21/12 the physician was notified of current and previous change of condition by nurse on duty. An inservice was held on 09/27/12. It is the policy of this facility to immediately notify the physician when a resident's condition changes and when medication that the physician has ordered is unavailable. 1. <u>What corrective action will be done by the facility?</u> Physicians and families were notified of identified medication omissions. Resident #3, #6, and #9 are receiving medications as ordered with no unavailability of the medication and the lack of a physician's prescription. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> There have been no other residents identified as being affected by this practice; however, if the Director of Nursing finds that the nurses has not notified the physician of a resident has had a change in condition or other significant issue, she will make sure that the physician is notified immediately and that all orders are transcribed and acted upon. Once that is done and the resident is cared for, the DON will re-train the nurse involved regarding the facility policy for physician notification. In addition, the DON will render progressive</p>				

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	<p>indicated the nurse should have notified the physician of the incident, especially since this was unusual for the resident.</p> <p>B) The Physician's Recapitulation Orders, dated 09/12, indicated an order for fentanyl patch 12 mcg/hour, apply one patch every three days.</p> <p>The MAR (Medication Administration Record), dated 06/12, indicated the fentanyl was not given on June 14 and 27, 2012, with no reason documented.</p> <p>The MAR, dated 07/12, indicated the patch was held on July 10 and 13, 2012 due to being unavailable, and the pharmacy was made aware on 07/10/12.</p> <p>There was a lack of documentation to indicate the resident's physician had been notified the medication had not been given as ordered.</p> <p>2. Resident #6's record was reviewed on 08/30/12 at 2 p.m. The resident's diagnoses included, but were not limited to, paranoid state, diabetes mellitus, dementia, and anxiety.</p> <p>A pharmacy recommendation, dated 08/17/12, indicated the resident was receiving Navane (antipsychotic) 10 mg twice a day, and the resident was</p>		<p>disciplinary action for continued noncompliance. The Director of Nursing or designee will review the 24 hour condition change report and the focused charting (nurses' notes) at least five days a week to ensure notifications are completed 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing or Designee will review the focused charting and the 24 hour condition change report at least 5 days each week. The review will be completed just prior to the morning meeting. Any change of resident condition will be reviewed by the Interdisciplinary team during the morning meeting ensuring that physician notifications are completed and documented appropriately in the residents' medical records. In addition, the DON will notify the IDT of any medication that is unavailable, including Schedule II drugs, due to lack of a physician's prescription. The Administrator and/or DON will assist the pharmacy in obtaining the needed prescription. The Administrator will contact the Medical Director to notify him of continuing issues with specific physicians in this regard and will ask for his assistance if needed. To ensure medications are administered as ordered, the Director of Nursing or designee will review the medication administration records three days each week for 30 days</p>		

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	<p>continuing to have hallucinations, and the pharmacist recommended the Navane be increased to 15 mg twice a day.</p> <p>A Physician's Telephone order, dated 08/20/12, indicated to discontinue the current Navane order and to start Navane 15 mg twice a day.</p> <p>The MAR, dated 08/12, indicated the resident received 15 mg of Navane on 08/24/12 at 8 a.m., and the initials were circled for the dose at 8 p.m., indicating the medication was not given. The MAR indicated the initials were circled for the 8 a.m. and 8 p.m. dose on August 25, 26, 27, and 28, 2012.</p> <p>The back of MAR indicated on August 25 at 8 a.m. and 8 p.m., 26 at 8 a.m. and 8 p.m., 27 at 8 a.m. and 8 p.m., and 28 at 8 a.m. and 8 p.m., the Navane was not available.</p> <p>There was a lack of documentation to indicate the resident's physician had been notified the medication had not been given as ordered.</p> <p>3. Resident #3's record was reviewed on 08/29/12 at 4 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, osteoarthritis, and macular degeneration.</p>		<p>and then weekly for 60 days. If the DON finds any issue related to physician notification that did not occur when a resident's condition changed or when medications were unavailable, she will follow up with the nurse(s) as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Results of audits of the Medication Administration Record, as well as the focused charting and twenty-four hour report review will be forwarded to the monthly QA&A committee for 90 days for the QA Committee's review and recommendations for further process improvement. Once 100% compliance is obtained the QA Committee may determine that there is no longer a need for the written audits; however, the DON's review of the focus charting, 24 hour report, and periodic MAR checks will continue on an ongoing basis. Date of Compliance: 10/4/12</u></p>		

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	<p>The Physician's Recapitulation Orders, dated 07/12, indicated an order, dated 07/09/11, for a fentanyl patch 50 mcg (micrograms) per hour, apply one patch every three days.</p> <p>The Medication Administration Record (MAR), dated 06/12, indicated the patch was not given on 06/02/12 and 06/05/12 as ordered due to the medication was unavailable.</p> <p>The MAR, dated 07/12, indicated the fentanyl patch not given due to being unavailable on July 22, 25, and 28, 2012.</p> <p>There was a lack of documentation to indicate the physician had been notified prior to 07/27/12 in regard to the resident not receiving the medication as ordered. A fax sheet to the physician, dated 07/27/12, indicated the pharmacy needed a signed script for the patch.</p> <p>4. Resident #9's record was reviewed on 08/30/12 at 5 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, left breast mastectomy, and seizures.</p> <p>The Physician's Recapitulation Orders, dated 06/12 and 08/12, indicated an order, originally dated 02/29/12, for fentanyl</p>						

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	<p>patch 12 mcg/hour, apply every three days.</p> <p>The MAR, dated 06/12, indicated the patch was not given on June 17, 20, 23, 26, and 29, due to the medication was not available, and the pharmacy was notified on 06/17/12.</p> <p>The MAR, dated 07/12, indicated the fentanyl was not given as ordered on 07/24/12 due to the medication being unavailable.</p> <p>There was a lack of documentation to indicate the resident's physician had been notified the resident had not received the fentanyl patch as ordered.</p> <p>During an interview on 08/31/12 at 1:50 p.m., the DoN was unable to say if the residents' physician had been notified the fentanyl patch had not been given.</p> <p>A facility policy, dated 06/04, titled, "Change of Condition", received from the Administrator as current, indicated, "...The resident's primary physician...will be notified immediately of any change in the resident's physical or mental condition...examples of significant change include, but are not limited to:...Change in level of consciousness...."</p>						

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	3.1-5(a)(2) 3.1-5(a)(3)			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed related to medications, diets, and obtaining blood pressures for 3 of 10 residents reviewed for physician's orders in a total sample of 10. (Residents #1, #6, and #18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident #1's record was reviewed on 08/31/12 at 11:50 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus. <p>The Physician's Recapitulation orders, dated 08/12, indicated an order, originally dated 11/26/08, to obtain a blood pressure weekly.</p> <p>The resident's Vital Sign Flow Sheet Record, indicated the resident's blood pressure was obtained on 05/16/12, 07/25/12, and 08/08/12.</p> <p>During an interview on 08/31/12 at 12:25 p.m., the Director of Nursing (DoN) indicated she could not find where any</p>	F0282	<p><u>F282</u></p> <p>F282: Please indicate if any observations will be made of meal to ensure Residents receive the correct diet, if so please indicate who will be doing the observations, the frequency of the observations, and if all meals will be included. DSM will monitor meals and handwashing 3 times a week on various meals for 30 days, then weekly for 30 days. It is the policy of this facility to follow all physician orders, including those for medications, diets, and obtaining blood pressures. <u>1. What corrective action will be done by the facility?</u> Resident #1 no longer requires a weekly blood pressure and the order was discontinued on August 31, 2012. Residents #6 and #18 are receiving medications as per the physicians' current orders. The Director of Nursing will present an inservice for all licensed nurses on the process of order transcription and the follow through needed on all physician orders, including those for blood pressures, diets, and medications on September 27, 2012. <u>2. How will the facility identify other residents having the potential to be affected by the same practice</u></p>	10/04/2012			

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	<p>more blood pressures had been taken.</p> <p>2. Resident #6's record was reviewed on 08/30/12 at 2 p.m. The resident's diagnoses included, but were not limited to, paranoid state, diabetes mellitus, dementia, and anxiety.</p> <p>A) A Physician's Telephone Order, dated 07/17/12, indicated, "Decrease Seroquel (antipsychotic) by 50 mg (milligram) Q (every) Wk (week) till (sic) she is off..."</p> <p>The MAR (Medication Administration Record), dated 07/12, indicated the resident was on Seroquel 200 mg since 05/23/12. The MAR indicated the Seroquel was decreased to 150 mg from July 18-24, 2012 and decreased to 100 mg July 25-31, 2012.</p> <p>The MAR, dated 08/12, indicated the Seroquel had been decreased to 50 mg from August 1-4, 2012 (four days). The MAR indicated the resident had not received the 50 mg of Seroquel for one week.</p> <p>During an interview on 08/30/12 at 1:40 p.m., the DoN indicated the resident did not get the Seroquel reduced as ordered.</p> <p>B) A Physician's Telephone Order for Resident #6, dated 07/31/12 at 9:30 a.m.,</p>		<p><u>and what corrective action will be taken?</u> Orders received since September 1, 2012, have been reviewed to ensure transcription accuracy and placement on the treatment and medication records. Vitals will be completed for all residents as part of the weekly summary. The Dietary Manager and the DON have checked all current resident diets to make sure that they are accurate with the most recent physician orders. No other issues were identified. There have been no other residents identified as being affected by this practice; however, if the DON or designee finds that an order has not been transcribed correctly, she will make sure that it is corrected as soon as possible. Once that is done, the nurse who failed to transcribe the order correctly will receive additional training and progressive disciplinary action for continued noncompliance.</p> <p><u>3. What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing or designee will review the 24 hour report, focus charting, and physician telephone orders for any changes in medication or treatment orders at least five days per week on an ongoing basis. All new orders will be compared to the medication administration records and treatment records to ensure accuracy. The DON or designee will bring the results of those reviews to the morning</p>				

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	<p>indicated an order for Metform (sic) (diabetic medication) 500 XR (time release) daily.</p> <p>The MAR, dated 07/12, indicated the resident did not receive the medication on 07/31/12.</p> <p>The MAR, dated 08/12, lacked documentation to indicate the resident had an order for the Metformin and indicated the resident had not received the medication as ordered.</p> <p>During an interview on 08/30/12 at 2:30 p.m., the Administrator indicated she called the pharmacy and they were unaware of the Metformin order.</p> <p>During an interview on 08/30/12 at 3:55 p.m., the Administrator indicated the nurse put the Metformin on the July MAR but had not transcribed onto the August MAR. She indicated the nurses should check the medication sheets from month to month.</p> <p>C) A Pharmacy recommendation for Resident #6, dated 08/17/12, indicated the resident was receiving Navane (antipsychotic) 10 mg twice a day, and the resident was continuing to have hallucinations, and the pharmacist recommended the Navane be increased to</p>		<p>management IDT meeting that occurs at least 5 days a week for further review by the management team. If any concerns or issues are identified, the DON will follow through to make sure that the orders have been transcribed and put into place correctly. Once that is done, the DON will follow up with the nurse(s) involved as outlined in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring the results of the audits to the monthly QA&A committee meeting for review and recommendation for the next 90 days. Once that time period is completed, the QA&A Committee may decide to discontinue the written audits when 100% compliance has been achieved. Even when the written audits have been discontinued, the DON or designee will continue to check the focus charting, 24 hour report, physician orders, and the MAR/TAR on an ongoing basis.</u></p>		

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	<p>15 mg twice a day.</p> <p>A Physician's Telephone order, dated 08/20/12, indicated, to discontinue the current Navane order and to start Navane 15 mg twice a day.</p> <p>A Psychiatric note, dated 08/22/12, indicated, "...Cautiously optomistic (sic) we've found a better combination of meds (medications) for her behaviors/delusions. Navane recently increased (arrow up)..."</p> <p>The MAR, dated 08/12, indicated the resident received the Navane 15 mg twice a day on August 21, 22, and 23, 2012. The MAR indicated the resident received 15 mg of Navane on 08/24/12 at 8 a.m. and the initials were circled for the dose at 8 p.m., indicating the medication was not given. The MAR indicated the initials were circled for the 8 a.m. and 8 p.m. dose on August 25, 26, 27, and 28, 2012.</p> <p>The back of MAR indicated on August 25 at 8 a.m. and 8 p.m., 26 at 8 a.m. and 8 p.m., 27 at 8 a.m. and 8 p.m., and 28 at 8 a.m. and 8 p.m., the Navane was not available.</p> <p>During an interview on 08/30/12 at 1:30 p.m., the Director of Nursing (DoN) indicated she was unsure why the resident went four days without the Navane. She</p>						

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	<p>indicated the resident was on 10 mg and the pharmacy had sent out 5 mg of the Navane. She indicated the nurses had sent back the 10 mg to the pharmacy since it had been discontinued, thinking the pharmacy would send 15 mg of Navane to the facility, but the medication does not come in 15 mg.</p> <p>During an interview on 08/30/12 at 2:45 p.m., the DoN indicated the pharmacy had sent 5 mg of the Navane to the facility, and the staff were giving three tablets at a time for the 15 mg dose, so the facility had ran out of the Navane.</p> <p>During an interview on 08/30/12 at 2:45 p.m., the Administrator indicated the pharmacy should have sent enough Navane for the 15 mg order.</p> <p>D) During the supper meal observation on 08/29/12 at 5 p.m., Resident #6 received her supper, which included a grilled ham and cheese sandwich and potato chips.</p> <p>A Physician's Telephone Order, dated 07/31/12, indicated an order for a no concentrated sweets diet, no starch and only carbohydrates from fruit and vegetables.</p> <p>During an interview, on 08/30/12 at 2:30 p.m., the Administrator indicated she</p>						

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	<p>would let the Dietary Manager know of the changed order.</p> <p>During an observation on 08/30/12 at 5 p.m., the resident received a breaded tenderloin and crinkled cut french fries.</p> <p>3. Resident #18's record was reviewed on 08/30/12 at 3:50 p.m. The resident's diagnoses included, but were not limited to, hypothyroidism and severe dementia.</p> <p>A) A Physician's Telephone Order, dated 07/03/12, indicated and order to discontinue levothyroxine (thyroid medication) 250 mcg (micrograms) daily and to start levothyroxine 200 mcg daily.</p> <p>The MAR, dated 07/12, indicated an order for levothyroxine 200 mcg every day. The area where the nurses sign where the medication was given had every other day blocked out. The MAR indicated the resident had not received the levothyroxine 200 mg on August 5, 9, and 11, 2012.</p> <p>During an interview on 08/30/12 at 4:30 p.m., the DoN indicated the levothyroxine had not been given as ordered by the resident's physician.</p> <p>B) A TSH (thyroid stimulating hormone) laboratory test, dated 08/03/12, indicated</p>				

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	<p>the resident's TSH was 0.11 (normal 0.34-4.82). The TSH result indicated the resident's physician had been notified of the result and an order was received to decrease the levothyroxine to 125 mcg every day.</p> <p>A Physician's Telephone Order, dated 08/03/12, indicated an order to discontinue the current levothyroxine order (200 mcg daily) and start levothyroxine 125 mcg daily.</p> <p>The MAR, dated 08/12, indicated the levothyroxine order was transcribed as levothyroxine 150 mcg daily and the 150 mcg had been given on 08/04/12.</p> <p>The MAR, dated 08/12, indicated on 08/05/12 the levothyroxine order had been rewritten for levothyroxine 125 mcg daily and 125 mcg had been given to the resident on 08/05/12.</p> <p>A Physician's Telephone Order, dated 08/05/12, indicated to discontinue the levothyroxine 125 mcg and start levothyroxine 150 mcg daily.</p> <p>The MAR, dated 08/12, indicated the levothyroxine 125 mcg had been rewritten on 08/05/12 and the order had been changed to levothyroxine 150 mcg daily.</p>			

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	<p>During an interview on 08/30/12 at 4:30 p.m., the DoN indicated the nurse wrote the order for levothyroxine 125 mcg on 08/03/12, then wrote the wrong dose on the MAR. She indicated when the nurse didn't have the medication in the medication cart, the nurse then obtained the medication from the Emergency Drug Kit (EDK) and gave 150 mcg. She indicated she had not seen a Medication Error report. She indicated the nurse then called the physician for a clarification.</p> <p>3.1-35(g)(2)</p>			

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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to accurately assess, and treat a pressure ulcer as ordered by the physician, which resulted in an acquired pressure ulcer worsening from a stage two (partial thickness loss of the skin) to a stage three (full thickness of tissue loss) for Resident #16 and failed to thoroughly assess two residents' stage two pressure ulcers for Residents #3 and #9. This deficient practice affected 3 of 3 residents with pressure ulcers in a total sample of 10.</p> <p>Findings include:</p> <p>1. During an observation on 08/31/12 at 10:10 a.m. with the Director of Nursing (DoN) and the Corporate RN Consultant present, the DoN described Resident #16's right buttock/coccyx pressure ulcer as 3.5 centimeters (cm) by 3 cm. The DoN then indicated there was tunneling at 12</p>	F0314	<p><u>F314</u></p> <p>- It is the policy of this facility to accurately assess and treat a pressure ulcer as ordered by the physician.</p> <p><u>1.What corrective action will be done by the facility?</u></p> <p>Resident #3 and resident #9 do not currently have skin breakdown or open areas. Specific treatment orders have been received for preventative skin cream for resident #3 and #9.</p> <p>Resident # 16 is scheduled for a wound clinic evaluation on 9/20/12. The pressure area is assessed with each dressing change and routinely measured by the Director of Nursing following facility policy/procedure. Treatment changes are recommended to the attending physician as needed including the</p>	10/04/2012			

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	<p>o'clock (area on the wound) and measured the tunneling with a paper measurement device at 0.1 cm, and the measured the depth of the rest of the wound at 0.5 cm. The DoN indicated that was all they had to measure depth of the wound. The Corporate RN Consultant indicated the depth needed to be measured with a Q-tip. The DoN then obtained a Q-tip and re-measured the tunnel area at 2.5 cm and the depth of the rest of the wound at 0.7 cm. The DoN described the wound as, "beefy red" and indicated the wound looked better than it did, "the other day."</p> <p>Resident #16's record was reviewed on 08/30/12 at 11 a.m. The resident's diagnoses included, but were not limited to, advanced dementia and hypertension.</p> <p>The resident's Quarterly Minimum Data Set Assessment (MDS), dated 07/17/12, indicated the resident was cognitively impaired, was totally dependent for all activities of daily living, was at risk for pressure ulcers, and did not have unhealed pressure ulcers.</p> <p>A care plan, dated 07/24/12, indicated the resident was at risk for skin breakdown. The interventions included, "...observe my skin daily and document on wkly (weekly) and prn (as needed)..."</p>		<p>referral to the wound clinic.</p> <p>- On 9/27/12, all licensed nurses will be inserviced by the Director of Nursing and the Nurse Consultant on the importance of preventative skin care and the facility policies and procedures for prevention, accurate assessment of wounds, using appropriate physician ordered medications and treatments for specific wounds, and the timely and accurate documentation of each. In addition, forms related to documentation of pressure sores and non-pressure sores, weekly skin assessments, and Braden assessments, and treatment administration will be reviewed.</p> <p>- <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>Head to toe skin assessments were completed for all residents on 8/31/12 and 9/1/12. There were no new wounds identified on any resident at that time.</p> <p>If the DON should find that the nursing staff has not followed through on any part of the pressure ulcer prevention, treatment, or documentation systems, she will intercede immediately to make sure that the resident is being appropriately cared for. When that is done, she</p>				

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	<p>An "Assessment of Other Skin Abnormalities," dated 07/25/12, indicated the resident had an open area on the coccyx area which measured 1.5 cm x 0.5 cm.</p> <p>A weekly pressure ulcer assessment, dated 07/25/12, indicated the resident had an in-house acquired stage one (intact skin with non-blanchable redness) area on the right buttock, which measured 2 cm x 3 cm x less than 0.2 cm (depth) (stage two), and the current treatment was Kenalog cream (fungal cream).</p> <p>During an interview on 08/30/12 at 1:45 p.m., the Administrator indicated the area on the buttock was open and was not a stage one.</p> <p>A fax form to the physician indicated the resident had an open area on her buttock at 1.5 cm x 0.5 cm and a Duoderm (skin protection dressing) was applied, and an order was requested to continue the Duoderm daily until the area was healed.</p> <p>A physician's order, dated 7/27/12, indicated to apply a Duoderm to the open area until healed daily.</p> <p>The Treatment Administration Record (TAR) indicated on 07/27/12, an order was written to apply a Duoderm to the</p>		<p>will re-train the nursing staff involved regarding the policy and procedure for the part of the skin system that the DON identified as lacking. She will also render progressive disciplinary action up to and including termination for continued noncompliance with any part of the skin/wound systems.</p> <p><u>3. What measures will be put into place to ensure that this practice does not recur?</u></p> <p>Preventative skin care is completed routinely for all resident. All residents have pressure relieving devices on beds and in wheelchairs or other seating such as recliners. Weekly head to toe skin assessments are completed along with the weekly summaries.</p> <p>A new weekly summary/weekly skin assessment "schedule board" is now in place in the nurses' station to remind the nurses when scheduled assessments are due.</p> <p>Braden assessments will be updated for all residents prior to 9/27/12 to make sure that staff is aware of the level of the residents' current skin risk for development of pressure ulcers and that the appropriate interventions are in place for prevention and treatment of skin issues.</p>		

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	<p>open area on the buttocks daily until healed. The TAR indicated a Duoderm was applied on 07/27/12.</p> <p>The TARs dated 07/12 and 08/12 lacked documentation to indicate the Duoderm had been removed or changed.</p> <p>The Nurses' Notes indicated: 07/28/12 at 1:30 a.m.-"Duoderm intact..." 07/29/12 at 2:30 a.m.-"Intact duoderm to buttock..." 07/31/12 at 1:50 a.m.- "checked resident duoderm intact..." 08/01/12 at 4:40 p.m.- "New Duoderm applied, area to coccyx remains open. Tender to touch" 08/02/12 at 1:50 a.m.-"Duoderm intact to coccyx..." 08/03/12 at 4:25 p.m., "Cream applied to coccyx area. Remains tender to touch..." 08/04/12 at 2:45 a.m., "Coccyx area remains tender to the touch..." 08/04/12 at 8:45 p.m., "Coccyx area continues to be tender to the touch..." 08/05/12 at 4:30 a.m., "Coccyx area tender to touch..." 08/05/12 at 9:30 p.m., "Coccyx area tender to touch..." 08/06/12 at 9:40 p.m., "Coccyx area continues to be tender to touch..." 08/07/12 at 8:25 p.m., "Coccyx remains tender to the touch..." 08/10/12 at 2:55 p.m., "Coccyx remains</p>		<p>Braden skin assessments are completed routinely for all residents at the time of admission, quarterly with the MDS and with a change in resident condition. Those residents with a Braden score <17 are considered high risk and a care plan has been developed. In addition, a resident who is incontinent of bowel or bladder and residents who have decreased mobility are routinely care planned for being at risk for skin breakdown.</p> <p>The skin prevention program includes weekly skin assessments, completion of shower sheets by direct care staff to alert nursing supervisors of possible skin concerns and pressure relieving devices and preventative skin creams/ointments. Pressure areas are assessed with each dressing change and routinely by the Director of Nursing following facility policy. Pressure areas are measured weekly by the Director of Nursing, the information is recorded and forwarded to the Administrator, as well as the Nurse Consultant and Director of Clinical Services for review. If the wound has not shown improvement for 2 weeks, the need for treatment change is addressed with the physician at that time.</p>	

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	<p>tender to touch..."</p> <p>08/11/12 at 1:40 a.m., "...Coccyx tender to touch and open...0/ (no) duoderm open to air..."</p> <p>The physician's order lacked documentation to indicate the duoderm had been discontinued.</p> <p>The Nurses' Notes indicated: 08/13/12 at 8 p.m., "Coccyx remains tender to touch..." 08/14/12 at 1:30 p.m., "...Skin assessment done. Skin on (R) (right) buttock cheek (sic) 3 cm x 2 cm open area Tender to touch...Hard area noted around area on (R) buttock. DON (Director of Nursing) notified and aware..." 08/14/12 at 4 p.m., "Rec'd (received) order from (Physician's Name) to use bioclusive (transparent dressing)...."</p> <p>The Nurses' Notes indicated the Duoderm had not been changed, and the open area was not assessed for description of the area after 08/02/12.</p> <p>The weekly pressure ulcer assessment indicated after 07/25/12 the next assessment of the open area was 08/17/12 (three weeks later), which indicated the area was now a stage three, with measurements of 3 cm x 3.5 cm with a 0.2 cm of depth, had no tunneling or</p>		<p>The Director of Nursing or Designee will review the focused charting, the 24 hour condition change report, and physician orders at least 5 days each week. The review will be completed just prior to the morning meeting. Any change of resident condition, including skin condition, will be reviewed by the Interdisciplinary team during the morning meeting ensuring that physician notifications are completed, documented appropriately, and transcribed to the resident's treatment administration record (TAR).</p> <p>The resident's care plan will be updated at that time with any new orders and interventions. When the meeting is done, the DON will note any new interventions on the 24 hour report sheet so that subsequent shifts are aware of any changes. The DON will also update the CNA assignment sheets with the new interventions.</p> <p>The Director of Nursing or designee will audit weekly skin assessments and weekly summaries for completion 3 times weekly for 30 days, then weekly for another 30 days to ensure completion and accuracy. Any identified issue will be dealt with as outlined in question #2.</p> <p>- <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what</u></p>		

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	<p>undermining, and had moderate amount of exudate.</p> <p>The weekly pressure ulcer assessment indicated the next assessment of the open area was 08/29/12 (12 days later) and the area continued to be a stage three, measurements were 3 cm x 4.53 cm with less than 0.5 cm depth, had tunneling less than .02, moderate amount and the last treatment change was 08/15/12, which was Calcium Alginate (wound dressing).</p> <p>The Nurses' Noted lacked documentation the physician had been notified of the buttock area being tender to touch. There was a lack of documentation to indicate the physician had been updated on the area until the area became a stage three. There was a lack of documentation to indicate the physician had been notified when the tunnel area had been found in the open area.</p> <p>There was a lack of documentation on the weekly pressure ulcer assessment to describe the color and odor of the exudate.</p> <p>During an interview on 08/30/12 at 11:40 a.m., the DoN indicated the nurses are supposed to be monitoring, assessing, and measuring the open areas weekly. She indicated the resident's open area started</p>		<p><u>QA will be put into place?</u></p> <p><u>The DON will bring the results of her reviews of the focus charting, 24 hour report, and physician orders related to residents' changing skin condition, as well as her audits of the weekly skin assessments and weekly summaries to the monthly QA&A committee meeting for review and recommendation for the next 60 days. Once that time period is completed, the QA Committee may decide to discontinue the written audits when 100% compliance has been achieved. However, the DON's review of the focus charting, 24 hour report, physician orders and skin conditions, and weekly summaries/skin assessments will continue on an ongoing basis.</u></p>		

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	<p>as a shearing. She indicated she was unsure if the area had been measured from 07/25/12 through 08/17/12.</p> <p>During an interview on 08/30/12 at 1:50 p.m., the Administrator indicated the area was a shear from the sheet, not a pressure area.</p> <p>2. During an observation on 08/30/12 at 3:35 p.m., with the DoN present, Resident #3's coccyx area had no open area. The area was described by the DoN as newly healed, pink, with fresh scar tissue.</p> <p>Resident #3's record was reviewed on 08/29/12 at 4 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and macular degeneration.</p> <p>The Significant Change MDS assessment, dated 05/23/12, indicated the resident had cognitive impairment, required extensive assistance for bed mobility and transfers, was always incontinent of urine, was at risk for pressure ulcers, and had no unhealed pressure ulcers.</p> <p>The Physician's Recapitulation Orders, dated 07/12, indicated an order, dated 06/22/12, for Duoderm to reddened area on buttocks, change every three days.</p>			

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	<p>A Nurses' Note, dated 06/22/12 at 9:45 p.m., indicated, "Duoderm applied to area on buttocks...Area measures 0.5 cm x 1 cm. Area next to it measures 1 cm x 1.5 cm (R) lower (arrow down) buttocks. Resident states she has been itching it..." The Nurses' Note lacked documentation to indicate a description of the area.</p> <p>The Nurses' Notes, dated 06/23/12 at 12:15 p.m. through 08/07/12 at 1:30 p.m., indicated the treatment continued and the Duoderm was intact.</p> <p>A Nurses' Note, dated 08/07/12 at 1:30 p.m., indicated the open areas to the coccyx remained.</p> <p>A Nurses' Note, dated 08/09/12 at 1:30 p.m., indicated the open area to the coccyx remained.</p> <p>A Nurses' Note, dated 08/15/12 at 11 p.m., indicated the open area to the coccyx was close to healing.</p> <p>A Nurses' Note, dated 08/20/12 at 10 p.m., indicated the Duoderm on the coccyx area was intact.</p> <p>There was a lack of documentation after 08/20/12 to indicate the area on the coccyx had been observed and assessed.</p>			

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	<p>There was a lack of documentation the area on the buttock had been assessed after it was found on 06/22/12 until the weekly summary, dated 07/13/12, which indicated the area was a red scabbed area.</p> <p>During an interview on 08/30/12 at 11:40 a.m., the DoN indicated she could not find a weekly skin assessment for the resident.</p> <p>3. Resident #9's record was reviewed on 08/30/12 at 5 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and seizures.</p> <p>The Annual MDS Assessment, dated 07/03/12, indicated the resident's cognition was impaired, required extensive assistance with bed mobility and transfers, was a risk for pressure ulcers, and had no unhealed pressure ulcers.</p> <p>A care plan, dated 07/10/12, indicated the resident was at risk for skin breakdown. The interventions included to observe the resident's skin daily for open areas and document weekly and as needed.</p> <p>A weekly skin assessment, dated 08/07/12, indicated the resident had an abrasion to the right buttock which was from shearing.</p>				

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	<p>A fax form, dated 08/13/12 at 12:40 p.m., indicated the resident had an open area 1 cm x 0.5 cm on the right buttock and requested a of Duoderm.</p> <p>A Physician's Telephone Order, dated 08/14/12, indicated an order for Duoderm to the buttock every three days or as needed.</p> <p>The Nurses' Notes indicated: 08/13/12 at 8 p.m., "...Duoderm to (R) buttock remains..." 08/14/12 at 1:45 a.m., "...Duoderm applied to coccyx...due to removal c/ (with) brief change..." 08/15/12 at 2 a.m., "...Duoderm intact to coccyx area..." 08/30/12 at 10:35 a.m., "...Duoderm intact to (R) buttock area..."</p> <p>The record lacked documentation to indicate the open area on the right buttock had been thoroughly assessed when found and assessed after 08/13/12.</p> <p>During an interview on 08/31/12, the Corporate RN Nurse Consultant indicated the weekly head to toe assessments of the residents had not been getting done. The Administrator indicated skin issues are discussed in morning meetings, and she was unaware of the area on Resident #9,</p>			

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	<p>and was unsure if she was aware of the area on Resident #3. The Administrator indicated if the nurses were doing the skin assessments like they were supposed to, she would have known about the areas.</p> <p>A facility policy, dated 06/04, titled, "Skin Assessments", received from the Administrator as current, indicated, "...The Director of Nursing or designated nurse will do weekly skin assessments on all residents...1. Head to toe assessments will be done weekly...Documentation of these skin assessments will be completed, using the 'Weekly Head-To-Toe Skin Assessment' form..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 3 of 10 residents in a sample of 10 (Residents #7, #18, and #20) observed receiving medications. 4 errors in medication administration were observed during 51 opportunities for error in medication administration. This resulted in a medication error rate of 7.84%.</p> <p>Findings include:</p> <p>1. During an observation on 08/31/12 at 8:15 a.m., LPN #1 prepared Resident #7's morning medications, which included Sinemet (Parkinson's Disease medication) 25-100 mg (milligrams), four times daily and Azulfidine (anti-inflammatory) 500 mg three times a day.</p> <p>LPN #1 prepared the resident's medications and then administered the medications to the resident at 8:20 a.m.</p> <p>Resident #7's record was reviewed on 08/31/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease and irritable</p>	F0332	<p><u>F332</u> It is the policy of this facility to ensure that medications are given as ordered and within the manufacturers' guidelines to prevent medication errors. The facility disagrees with 2 parts of the statement of deficiencies for F332 – parts #1 and #2 which cite the nurse for not giving certain medications according to a drug reference guide that the surveyor was using. We are requesting a paper IDR and are including information stating our position with the submission of this plan of correction. Even though we do not believe that some of what is stated is valid, we are providing a plan of correction as required by federal regulations. 1. <u>What corrective action will be done by the facility?</u> LPN #1 received disciplinary action for not giving Resident #20's eye drops as per the physician's order. In addition to the disciplinary action, LPN #1 has received medication administration retraining from the Director of Nursing. On 9/27/12, the Director of Nursing and Nurse Consultant will present an inservice that will include basic medication administration guidelines, including the need to follow physician orders and to heed manufacturer's guidelines</p>	10/04/2012

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	<p>bowel syndrome.</p> <p>The resident's Quarterly Minimum Data Set (MDS) Assessment, dated 06/06/12, indicated the resident had moderately impaired cognition, and had no behaviors.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated the following orders: Sinemet 25-100 mg, take one tablet by mouth four times daily, scheduled for 7 a.m., 11 a.m., 3 p.m., and 7 p.m.</p> <p>Azulfidine 500 mg, take one tablet by mouth three times daily, scheduled for 7 a.m., 3 p.m., and 7 p.m.</p> <p>A Professional Resource, titled, "Nursing Spectrum Drug Handbook 2010", "carbidopa-levodopa" (Sinemet), indicated to give dose as close as possible to time ordered to ensure stable drug blood level.</p> <p>A Profession Resource, titled, "Nursing Drug Guide", 2011 Lipincott indicated, sulfsalazine (Azulfidine)-Administer around-the- clock; dosage intervals should not exceed eight hours. Give after meals.</p> <p>During an interview on 08/31/12 at 9:30 a.m., the Administrator indicated the staff</p>		<p>for administering medications as specified by the pharmacy when filling and sending the ordered medications. Following the inservice, nurses must pass a medication administration competency test. The licensed nurses who are unable to attend this inservice will not be allowed to work until they have received the information and passed the competency test. All agency nurses will receive medication pass including competency test with orientation to the facility.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents residing in the facility and who receive medications have the potential to be affected by the alleged practice; however no residents were negatively affected by the identified medication errors and no further errors have occurred. In the future, if the DON observes or becomes aware that a medication error has occurred, she will intercede immediately to make sure that the resident is receiving what he/she has been ordered by the physician and will initiate a medication error sheet as indicated by the situation. Once that is done, she will investigate the situation fully and re-train the nurse(s) involved in the issue. She will also give progressive disciplinary action up to and</p>		

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	<p>have an hour lee-way for medications. She indicated the resident refuses to take her medications until after she eats. She indicated she was not sure why the times had not been changed so the resident's medications would be given to her after her meals. She indicated they would call the resident's physician and get an order to change the times of the medication.</p> <p>2. During an observation on 08/31/12 at 8:35 a.m., LPN #1 prepared and administered Resident #18's medication which included levothyroxine (hypothyroid medication) 150 mcg (micrograms) daily.</p> <p>The resident was sitting at the breakfast table and had just finished eating breakfast.</p> <p>Resident #18's record was reviewed on 08/30/12 at 3:50 p.m. The resident's diagnoses included, but were not limited to, hypothyroidism and severe dementia.</p> <p>A Physician's Telephone Order, dated 08/05/12, indicated an order for levothyroxine 150 mcg, one tablet daily.</p> <p>The Medication / Record (MAR), dated 08/12, indicated an order for levothyroxine 150 mcg give one tablet every day, and was scheduled for eight</p>		<p>including termination for any noncompliance related to medication administration. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing or designee will complete medication administration observations beginning October 1, 2012. These observations will be completed twice each week for 30 days and then weekly for 30 days. Results of the observations will be forwarded to the Administrator for further review. If it is determined that a nurse fails to administer medications according to standards of professional practice, the DON will follow through as indicated in question #2. The consultant pharmacist will continue to review all residents' medications at least monthly and will continue to monitor their use closely, including the timing and manner in which the doses are given. If the pharmacist finds any issues, he will report them to the Administrator and DON during his visit. The Administrator or DON will follow up accordingly, including making sure that necessary re-training and disciplinary action occur where indicated. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the medication administration observations, any</p>	

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	<p>a.m.</p> <p>During an interview on 08/30/12 at 3:55 p.m., the Administrator indicated the time for the levothyroxine was changed to 8 a.m. in August. She indicated the resident eats breakfast around 7:30 a.m.</p> <p>A Professional Resource, titled, "Nursing Drug Guide", 2011 Lipincott indicated levothyroxine is to be administered before breakfast with a full glass of water.</p> <p>3. During an observation on 08/31/12 at 8:45 a.m., LPN #1 prepared Resident #20's medications, which included artificial tears (eye drops), one drop into the right eye twice a day.</p> <p>LPN #1 entered the resident's room at 8:55 a.m. and administered one drop of the artificial tears into the resident's left eye, then administered one drop of the artificial tears into the right eye.</p> <p>The resident's record was reviewed on 08/29/12 at 4:30 p.m. The resident's diagnoses included, but were not limited to, dysphasia and dementia.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated and order, originally written on 02/20/12 for artificial tears, instill one drop in the right</p>		<p>identified medication errors, and any issues identified by the consultant pharmacist, to the monthly QA&A Committee for review and recommendations. Once the 60 days has passed, the QA Committee may decide to stop the written medication observations once 100% compliance is obtained. However, the DON will continue to monitor medication administration as it occurs and will follow up on any concerns from those observations or from the consultant pharmacist's findings as a result of his reviews. This will continue on an ongoing basis.</p>				

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	<p>eye twice daily.</p> <p>During an interview on 08/31/12 at 9:40 a.m., LPN #1 indicated she administered the artificial tears into the right and the left eye.</p> <p>A facility policy, dated 06/04, titled, "Eye Medication, Instillation", received from the Administrator as current, indicated, "...Check the medication label and order. Make sure you know which eye to treat..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F0333 SS=E	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure residents were free of a significant medication error related to not administering a routine narcotic pain patch as ordered by a physician for 3 of 3 residents with orders for fentanyl (narcotic pain medication) patches in a total sample of 10 (Residents #3, #9, and #22) and 1 of 1 resident reviewed for fentanyl patch orders in a supplemental sample of 3 (Resident #10)</p> <p>Findings include:</p> <p>1. Resident #3's record was reviewed on 08/29/12 at 4 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, osteoarthritis, and macular degeneration.</p> <p>The Significant Change MDS assessment, dated 05/23/12, indicated the resident had cognitive impairment, was on scheduled pain medication, and had no pain in the last five days.</p> <p>A care plan, dated 08/07/12, indicated the resident was at risk for increased pain. The interventions included, to observe</p>	F0333	<p>F333 It is the policy of this facility to ensure that residents are free of any significant medication errors, including administration of pain patches as ordered by the physician. <u>1. What corrective action will be done by the facility?</u> Resident #3 continues to receive pain relief through the use of a Fentanyl patch, 50mcg/hour, changed every three days. Resident #9 continues to receive pain relief through the use of a Fentanyl patch, 12mcg/hour changed every 3 days. Resident #22 continues to receive pain relief through use of a Fentanyl patch 12 mcg/hour changed every 3 days. The Director of Nursing will complete an inservice for nurses on 9/27/12 covering medication administration policies, including the process for administering all drugs as ordered by the physician, documenting controlled drugs and the need to count controlled drugs at the end of every shift, as well as to check the documentation of each on the "count" sheet for each drug. Nurses will also be instructed to place each count sheet in the individual resident's medical record when the form is completed. The nurses will also be inserviced on the pharmacy policy and procedure for obtaining</p>	10/04/2012			

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	<p>and treat pain.</p> <p>The Physician's Recapitulation Orders, dated 07/12, indicated an order, dated 07/09/11 for a fentanyl patch 50 mcg (micrograms) per hour, apply one patch every three days.</p> <p>The Medication Administration Record (MAR), dated 06/12, indicated the patch was not given on 06/02/12 and 06/05/12 as ordered due to the medication was unavailable. The MAR indicated the resident received the fentanyl patch on June 7, 13, 14, 18, 20, 23, and 27, 2012.</p> <p>The Controlled Drug Use Record, indicated the fentanyl patch was signed out on June 13 and 14 (daily), 2012, June 17 and 18 (daily), 2012, June 20, 2012 (two days), June 22, 2012 (two days), June 25 and June 27, 2012 (2 days), June 28, 2012 (one day), and June 30, 2012 (two days).</p> <p>The Nurses' notes indicated on 06/14/12 at 2:14 p.m. a new patch was applied, on 06/18/12 at 10:15 a.m. a new patch was applied, and on 06/19/12 at 11 a.m. the patch was intact.</p> <p>The MAR, dated 07/12, indicated the fentanyl patch was applied on July 4, 7, 10, 13, 16, 19, and 30, 2012. The MAR</p>		<p>prescriptions for Schedule II drugs so that those drugs can be sent for the residents in a timely manner. If the prescription is not obtained from the physician as quickly as needed, the nurses will be responsible to notify the physician of the unavailability of the medication. The nurses will notify the DON at that same time as to the unavailability of the medication and the lack of a physician's prescription.</p> <p>Following the inservice, all nurses will be tested to pass a medication administration competency test. <u>2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents receiving a narcotic patch for pain control have the potential to be affected. There have been no further identified concerns of narcotic pain patches being unavailable. In the future, if the DON finds an issue in regards to administration of medications, including not giving medications as ordered, medications being "unavailable", or not having accurate count sheets for controlled drugs, she will intercede immediately to make sure that the resident is receiving what he/she has been ordered by the physician and will initiate a medication error sheet if indicated by the situation. Once that is done, she will investigate the situation fully and re-train the</p>		

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	<p>indicated the fentanyl patch was held and not given due to being unavailable on July 22, 25, and 28, 2012. The MAR indicated the facility notified the pharmacy about the fentanyl patch on 07/25/12.</p> <p>The facility could not find a Controlled Drug Use Record for July.</p> <p>A fax sheet to the physician, dated 07/27/12, indicated the pharmacy still needed a signed script for the patch.</p> <p>An Emergency Drug Kit Usage Report indicated a fentanyl patch was used from the kit on 07/30/12.</p> <p>The Pharmacy shipping manifest indicated 10 patches of fentanyl were delivered on 06/11/12 and 9 patches were delivered to the facility on 06/30/12.</p> <p>During an interview on 08/30/12 at 9:10 a.m., the Director of Nursing (DoN) indicated she was told the patches were falling off all the time. She indicated two nurses should have destroyed the medications if it came off. She indicated there was nothing in the record to indicate the patches had come off early or where the other patch was. She indicated she did not know where the patches went.</p> <p>During an interview on 08/30/12 at 9:20</p>		<p>nurse(s) involved in the issue. She will also give progressive disciplinary action up to and including termination for any noncompliance related to medication administration 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> All licensed nurses will routinely complete a narcotic count between shifts and complete walking rounds to the room of each resident who has a Fentanyl patch ordered by the physician in order to visualize placement of the Fentanyl patch. The nurses will then sign on the medication administration record, indicating that the patch is present. The Director of Nursing now reviews the completed narcotic count sheet prior to placement in the residents' medical record. Pain assessments will be updated by 9/27/12 for all residents receiving a pain patch to ensure effectiveness. If there is any change in the pain assessment outcome, the physician will be notified. The Director of Nursing or designee will complete an audit of the medication Administration record and the controlled drug count sheets three times a week for 30 days and then weekly for 30 days to ensure medications are given as scheduled. Any medications that have been circled indicating the medication was not given must have a detailed explanation on the</p>				

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	<p>a.m., the Administrator indicated two of the nurses were no longer employed at the facility. She indicated she had been told the patches were rolling off the resident and they were applying new patches.</p> <p>During an interview on 08/30/12 at 11:40 a.m., the DoN indicated the staff are to notify the pharmacy who will notify the physician's office, then if the physician's office does not get back to pharmacy, they will call the facility to notify the physician.</p> <p>2. Resident #9's record was reviewed on 08/30/12 at 5 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, left breast mastectomy, and seizures.</p> <p>The Annual MDS Assessment, dated 07/03/12, indicated the resident's cognition was impaired, was unable to make herself understood, received scheduled pain medications, was unable to assess pain due to the resident was rarely/never understood, and had no indicators of pain in the last five days.</p> <p>The Physician's Recapitulation Orders, dated 06/12 and 08/12, indicated an order, originally dated 02/29/12 for fentanyl patch 12 mcg/hour, apply every three days.</p>		<p>reverse side of the medication administration record. A nurse, who circles a medication as not being given but fails to document the explanation, will receive retraining of the proper procedure and disciplinary action. If the DON or designee find any other issues, the DON will follow through with the nurse(s) involved as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- Results of the medication administration record and controlled drug count sheets audit will be reviewed at the monthly QA&A committee meeting for 60 days. Once 100% compliance is obtained the QA&A Committee may decide to stop the written audits; however, the checking of the DON or designee of the MARs and controlled drug sheets will continue on an ongoing basis.</p>				

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	<p>The MAR, dated 06/12, indicated the the fentanyl patch was applied on June 2, 5, 8, 11 and 14, 2012. The MAR indicated the patch was not given on June 17, 20, 23, 26, and 29, due to the medication was not available and the pharmacy was notified on 06/17/12.</p> <p>The Controlled Drug Use Record, indicated the fentanyl patch was signed out and given on June 5, 6, 8, 11, 13, and 14, 2012.</p> <p>A Nurses' Note, dated 06/14/12 at 1:15 p.m., indicated, "...Fentanyl patch remains on (R) (right) shoulder..."</p> <p>A Nurses' Note, dated 06/29/12 at 8 a.m., indicated, "Spoke c/ (with) (Physician's name) regarding order for Fentanyl Patch...will place order today..."</p> <p>The MAR, dated 07/12 indicated the fentanyl patch was applied on July 3, 6, 9, 12, 15, 18, 21, 27, and 30, 2012, which indicated the resident went from June 14, 2012 to July 3, 2012 without the fentanyl patch (missing five doses). The MAR indicated the fentanyl was not given as ordered on 07/24/12 due to the medication being unavailable.</p> <p>The facility could not find a Controlled</p>						

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	<p>Drug Use Record from 06/12/12 through 07/27/12.</p> <p>During an interview on 08/30/12 at 4:55 p.m., the Administrator indicated she did not know where the patches went and was unsure why the medication was not given. She indicated this was the second controlled count sheet that was missing.</p> <p>3. Resident #22's record was reviewed on 08/31/12 at 12:20 p.m. The resident's diagnoses included, but were not limited to, spinal stenosis, non-Hodgkin lymphoma, and dementia.</p> <p>The Quarterly MDS Assessment, dated 08/15/12, indicated the resident could make herself understood, was cognitively intact, received scheduled pain medication, and had no pain in the last five days.</p> <p>The Physician's Recapitulation Orders, dated 09/12, indicated an order for fentanyl patch 12 mcg/hour, apply one patch every three days.</p> <p>The MAR, dated 06/12, indicated the resident received the fentanyl on June 2, 5, 8, 11, 15, 18, 21, 24, and 30, 2012. The MAR indicated the fentanyl was not given on June 14 and 27, 2012, no reason documented.</p>				

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	<p>A Controlled Drug Use Record, indicated the fentanyl patch was signed out as given on June 15, 18, 20, 21, 24, 27, 29, 2012,</p> <p>The Nurses' Notes indicated: 06/14/12 at 1 p.m.-"...Back and shoulder pain assessed. Hydrocodine (pain med) administered..." 06/15/12 at 10:15 a.m.-"...c/o (complains of) pain to lower back and shoulders...prn (as needed) pain med administered..."</p> <p>The MAR, dated 07/12, indicated the resident received the patch on July 2, 4, 5, 7, 14, 16, 17, 20, 23, 26, and 29, 2012. The MAR indicated the patch was held on July 10 and 13, 2012 due to unavailable and the pharmacy was made aware on 07/10/12.</p> <p>The Nurses' Notes indicated: 07/10/12 at 11:45 a.m.-"...Pain noted to shoulders and under (L) (left) side...prn med administered" 07/11/12 at 1:50 p.m.-"...Generalized pain noted. PRN pain med administered..." 07/12/12 at 10:45 a.m.-"...fentanyl patch intact to upper (arrow up) mid back...vicodin (pain medicine) administered for pain..."</p> <p>A Controlled Drug Use Record, indicated the fentanyl patch was signed out as given</p>			

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	<p>July 2, 4, and 7, 2012.</p> <p>A Controlled Drug Use Record indicated the fentanyl patch was signed out as given on July 14, 17, 20, 23, 26, and 29, 2012.</p> <p>During an interview on 08/31/12 at 1:50 p.m., the DoN acknowledged the resident had not received the fentanyl patch as ordered.</p> <p>4. Resident #10's record was reviewed on 09/04/12 at 11 a.m. The resident's diagnoses included, but were not limited to, pain and hypertension.</p> <p>The Physician's Recapitulation Orders, dated 09/12, indicated an order originally dated 06/04/12 for fentanyl patch 25 mcg/hour, apply one patch every three days.</p> <p>The MAR, dated 08/12, indicated the resident had received the fentanyl patch on August 12, 15, 18, 21, 24, 27, and 30, 2012.</p> <p>The MAR, dated 09/12, indicated the resident had received the fentanyl patch on September 2, 2012.</p> <p>The Controlled Drug Use Record, indicated 10 patches were received from pharmacy on 08/09/12, and the fentanyl</p>				

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	<p>patch had been signed out as given on August 12, 15, 18, 21, 24, 30, and September 2, 2012, which indicated the resident did not have a patch signed out on August 27, 2012.</p> <p>During a narcotic count observation with LPN #3 on 09/04/12 at 10:35 a.m., the resident's fentanyl patch count was correct with three patches left out of the 10 patches delivered from the pharmacy on 08/09/12.</p> <p>During an interview on 09/04/12 at 10:55 a.m., the DoN indicated the fentanyl patch could not have been given as signed on the MAR if the count was correct.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>			

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F0354 SS=F	<p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>Based on record review and interview, the facility failed to have a RN present in the building for at least 8 consecutive hours a day for 2 days out of 7. This had the potential to affect 21 of 21 residents.</p> <p>Findings include:</p> <p>Review of the Nursing staff schedules, dated 08/22/12 through 08/29/12, indicated there was a lack of documentation to indicate a RN was in the building for 8 consecutive hours on 08/25/12 and 08/26/12.</p> <p>During an interview on 08/30/12 at 10:10 a.m., the Administrator indicated there was no RN coverage for 08/25/12 and 08/26/12. She indicated there was always</p>	F0354	<p><u>F354</u></p> <p>It is the policy of this facility to provide services of a registered nurse for at least 8 consecutive hours a day seven days a week.</p> <p><u>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- There were no residents affected by this practice; however, the Administrator will review the requirement for 8 consecutive hours of an RN in the facility 7 days a week.</p>	10/04/2012			

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	<p>an RN on call.</p> <p>3.1-17(b)(3)</p>		<p><u>2.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 deficient practice. The current work schedule has been revised to ensure proper staffing of registered nurse coverage for 8 consecutive hours 7 days a week.</p> <p><u>3.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 schedule to ensure proper staffing of registered nurse coverage has been implemented immediately. The DON or designee will monitor staff schedules on a daily basis to ensure registered nurse coverage is in place for weekends as well as during week times. The DON will notify the</p>	

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			<p>Administrator immediately of any concerns that she may have over her ability to cover the schedule with 8 hour RN coverage for any day of the week. The Administrator and DON will work together at that time to procure RN coverage, including the use of temporary staffing if needed to meet the requirement.</p> <p>- <u>4.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 bring any identified issues and concerns with the required registered nurse coverage to the QA&A committee for further review at the monthly meetings. Any recommendations made by the committee will be followed up by the DON and the results of those recommendations will be brought back to the next monthly QA meeting for</p>		

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			discussion. This will occur on an ongoing basis.	

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F0365 SS=D	<p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, record review, and interview, the facility failed to serve food in a form to meet the needs of the resident and as ordered by the physician for 1 of 7 residents on a therapeutic diet in a total sample of 10. (Resident #20)</p> <p>Findings include:</p> <p>During the supper meal observation on 08/29/12 at 5 p.m., Resident #20 received a club sub sandwich, made of sliced turkey, bacon, which were in 2-3 inch strips, tomato and whole lettuce leaf and potato chips.</p> <p>The resident's record was reviewed on 08/29/12 at 4:30 p.m. The resident's diagnoses included, but were not limited to, dysphasia and dementia.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated and order originally dated 10/15/10 for a mechanical soft diet with ground moist meats.</p> <p>During an interview with the Dietary Manager on 08/29/12 at 5:10 p.m., she</p>	F0365	<p><u>F365</u></p> <p>- It is the policy of this facility to serve food in a form that meets the needs of the residents and is in accordance with the physicians' orders.</p> <p>- <u>1. What corrective action will be done by the facility?</u></p> <p>Resident #20 had an order for a mechanical soft diet with moist meats and was immediately served the appropriate diet at the time of the survey.</p> <p>On 9/11/12, the dietitian discussed the concern of not following the mechanical soft diet as ordered by the physician with the dietary manager. The diet was then reviewed and the correct diet was served in the presence of the dietitian</p> <p>During the nursing inservice scheduled for September 27, 2012, the Director of Nursing will review the nursing to dietary communication form that is to be used to communicate diet orders to the dietary department when received from the physician.</p> <p>- <u>2. How will the facility identify</u></p>	10/04/2012	

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	<p>indicated the turkey was shaved but not ground. She indicated the bacon was not cut up enough.</p> <p>The spread sheet received from the Dietary Manager as current on 08/30/12, titled, "Week 2 Day 4", indicated the for a mechanical soft diet, the resident should have received a club sub sandwich with ground meat and creamy macaroni and cheese.</p> <p>3.1-21(a)(3)</p>		<p><u>other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents have the potential to be affected but no other residents were served the wrong diet.</p> <p>If any staff member observes that a resident is receiving food not in accordance with his/her diet order, the Dietary Manager and/or the Administrator will be notified immediately. Once the resident has the appropriate diet, the Administrator or Dietary Manager will review the facility policy regarding serving the physician ordered diet to the residents with the dietary staff involved in the issue. The Dietary Manager will render progressive disciplinary action for continued noncompliance in this area.</p> <p>- <u>3.What measures will be put into place to ensure that this practice does not recur?</u></p> <p>- The dietary manager will complete random meal audits to ensure the appropriate diets are being served as ordered by the physician. The audits will be completed 3 days a week during different meal times for 30 days and then weekly for 30 days.</p> <p>If any concerns are identified, the Dietary Manager will address them as outlined in question #2.</p>		

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			<p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>Results of the meal audits will be reviewed at the monthly QA&A committee meeting for 60 days. Once 100% compliance has been obtained the QA&A Committee may decide to stop the written audits. However, the Administrator and Dietary Manager will continue to check resident meals periodically on an ongoing basis. The consultant RD will also check the meals for accuracy as part of her consultation visits which occur twice a month.</p>	

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F0425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <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. Based on record review and interview, the facility failed to ensure an adequate amount of medication was received from the pharmacy, related to 4 residents not receiving a doses of medication as ordered by the physician for 4 of 10 residents reviewed for receiving medications in a sample of 10. (Residents #3, #6, #9, and #22)</p> <p>Findings include:</p> <p>1. Resident #6's record was reviewed on 08/30/12 at 2 p.m. The resident's diagnoses included, but were not limited</p>	F0425	<p><u>F425</u></p> <p>- It is the policy of this facility to ensure that an adequate amount of medication is received from the pharmacy and that residents receive the medication ordered by the physician.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>- Resident #3, #6, #9 and #22 are all receiving medications as ordered and in a timely manner. Residents #3, #6, #9 and #22 have had pain assessments updated to ensure pain medication is effective as ordered</p>	10/04/2012

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	<p>to, paranoid state, diabetes mellitus, dementia, and anxiety.</p> <p>A Physician's Telephone, dated 08/20/12, indicated, to discontinue the current Navane order and to start Navane 15 mg twice a day.</p> <p>The MAR, dated 08/12, indicated the resident received the Navane 15 mg twice a day on August 21, 22, and 23, 2012. The MAR indicated the resident received 15 mg of Navane on 08/24/12 at 8 a.m. and the initials were circled for the dose at 8 p.m. The MAR indicated the initials were circled for the 8 a.m. and 8 p.m. dose on August 25, 26, 27, and 28, 2012.</p> <p>The back of MAR indicated on August 25 at 8 a.m. and 8 p.m., 26 at 8 a.m. and 8 p.m., 27 at 8 a.m. and 8 p.m., and 28 at 8 a.m. and 8 p.m., the Navane was not available.</p> <p>During an interview on 08/30/12 at 1:30 p.m., the Director of Nursing (DoN) indicated she was unsure why the resident went four days without the Navane. She indicated the resident was on 10 mg and the pharmacy had sent out 5 mg of the Navane. She indicated the nurses had sent back the 10 mg to the pharmacy since it had been discontinued thinking the pharmacy would send 15 mg of Navane to</p>		<p>Resident #6 receives Navane 5mg and Navane 10mg to equal the 15mg as ordered.</p> <p>Resident #3 continues to receive pain relief through the use of a Fentanyl patch, 50mcg/hour, changed every three days.</p> <p>Resident #22 continues to receive pain relief through use of a Fentanyl patch 12 mcg/hour changed every 3 days.</p> <p>Resident #9 continues to receive pain relief through the use of a Fentanyl patch, 12mcg/hour changed every 3 days.</p> <p>On September 27, 2012, the Director of Nursing and Nurse Consultant will inservice the licensed nurses on the importance of giving medications as ordered by the physician.</p> <p>The nurses will also be inserviced on the pharmacy policy and procedure for obtaining prescriptions for Schedule II drugs so that those drugs can be sent for the residents in a timely manner. If the prescription is not obtained from the physician as quickly as needed, the nurses will be responsible to notify the physician of the unavailability of the medication. The nurses will notify the DON at that same time as to the unavailability of the medication and the lack of a</p>				

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	<p>the facility but the medication does not come in 15 mg.</p> <p>During an interview on 08/30/12 at 2:45 p.m., the DoN indicated the pharmacy had sent 5 mg of the Navane to the facility and the staff were giving three tablets at a time for the 15 mg dose, so the facility had ran out of the Navane.</p> <p>During an interview on 08/30/12 at 2:45 p.m., the Administrator indicated the pharmacy should have sent enough Navane for the 15 mg order.</p> <p>2. Resident #3's record was reviewed on 08/29/12 at 4 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, osteoarthritis, and macular degeneration.</p> <p>The Physician's Recapitulation Orders, dated 07/12, indicated an order, dated 07/09/11 for a fentanyl patch 50 mcg (micrograms) per hour, apply one patch every three days.</p> <p>The Medication Administration Record (MAR), dated 06/12, indicated the patch was not given on 06/02/12 and 06/05/12 as ordered due to the medication was unavailable.</p> <p>The MAR, dated 07/12, indicated the</p>		<p>physician's prescription.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents receiving narcotic or psychotropic drugs have the potential to be affected. No other residents have been found to be negatively affected.</p> <p>In the future, if the DON finds an issue in regards to administration of medications, including not giving medications as ordered, medications being "unavailable", or not having enough medications, she will intercede immediately to make sure that the resident is receiving what he/she has been ordered by the physician and will initiate a medication error sheet if indicated by the situation.</p> <p>Once that is done, she will investigate the situation fully and re-train the nurse(s) involved in the issue. She will also give progressive disciplinary action up to and including termination for any noncompliance related to medication administration</p> <p>3. <u>What measures will be put into place to ensure that this practice does not recur?</u></p> <p>The Director of Nursing or</p>				

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	<p>fentanyl patch was held not given due to being unavailable on July 22, 25, and 28, 2012. The MAR indicated the pharmacy was made aware they resident needed the fentanyl patch on 07/25/12.</p> <p>A fax sheet to the physician, dated 07/27/12, indicated the pharmacy still needed a signed script for the patch.</p> <p>During an interview on 08/30/12 at 11:40 a.m., the DoN indicated the staff are to notify the pharmacy who will notify the physician's office, then if the physician's office does not get back to pharmacy they will call the facility to notify the physician.</p> <p>3. Resident #9's record was reviewed on 08/30/12 at 5 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, left breast mastectomy, and seizures.</p> <p>The Physician's Recapitulation Orders, dated 06/12 and 08/12, indicated an order, originally dated 02/29/12 for fentanyl patch 12 mcg/hour, apply every three days.</p> <p>The MAR, dated 06/12, indicated the patch was not given on June 17, 20, 23, 26, and 29, due to the medication was not available and the pharmacy was notified</p>		<p>designee will complete an audit of the medication Administration record three times a week for 30 days and then weekly for 30 days to ensure medications are given as scheduled. Any medications that have been circled indicating the medication was not given must have a detailed explanation on the reverse side of the medication administration record. A nurse, who circles a medication as not being given but fails to document the explanation, will receive retraining of the proper procedure and disciplinary action. If the DON or designee finds any other issues, the DON will follow through with the nurse(s) involved as indicated in question #2.</p> <p>- <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- Results of the medication administration record and controlled drug count sheets audit will be reviewed at the monthly QA&A committee meeting for 60 days. Once 100% compliance is obtained the QA&A Committee may decide to stop the written audits; however, the checking of the DON or designee of the MARs will continue on an ongoing basis.</p>		

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	<p>on 06/17/12.</p> <p>A Nurses' Note, dated 06/29/12 at 8 a.m., indicated, "Spoke c/ (with) (Physician's name) regarding order for Fentanyl Patch...will place order today..."</p> <p>The MAR, dated 07/12, indicated the fentanyl was not given as ordered on 07/24/12 due to the medication being unavailable.</p> <p>4. Resident #22's record was reviewed on 08/31/12 at 12:20 p.m. The resident's diagnoses included, but were not limited to, spinal stenosis, non-Hodgkin lymphoma, and dementia.</p> <p>The Physician's Recapitulation Orders, dated 09/12, indicated an order for fentanyl patch 12 mcg/hour, apply one patch every three days.</p> <p>The MAR, dated 07/12, indicated the patch was not administered on July 10 and 13, 2012 due to unavailable and the pharmacy was made aware on 07/10/12.</p> <p>During an interview on 08/31/12 at 1:50 p.m., the DoN acknowledged the resident had not received the fentanyl patch as ordered.</p> <p>A pharmacy policy, dated 12/09, titled,</p>				

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	<p>"Medication Orders", received from the DoN as current, indicated, "...Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe. the written prescription may be faxed to the pharmacy...The prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available...if a new prescription is not obtained by the pharmacy before the medication would be "due" again, the facility is notified. in this situation, the facility may be asked to contact the prescriber for a new prescription prior to the medication running out..."</p> <p>3.1-25(a)</p>			

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review and interview, the facility failed to ensure an accurate account of a controlled drug was maintained and reconciled, related to the</p>	F0431	<p><u>F431</u></p> <p>- It is the policy of this facility to ensure that an accurate account of a controlled drug is maintained</p>	10/04/2012			

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	<p>amount of fentanyl (narcotic) patches which were given and signed out for 3 of 3 residents with orders for fentanyl patches in a sample of 10. (Residents #3, #9, and #22)</p> <p>Findings include:</p> <p>1. Resident #3's record was reviewed on 08/29/12 at 4 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, osteoarthritis, and macular degeneration.</p> <p>The Physician's Recapitulation Orders, dated 07/12, indicated an order, dated 07/09/11 for a fentanyl patch 50 mcg (micrograms) per hour, apply one patch every three days.</p> <p>The Medication Administration Record (MAR), dated 06/12, indicated the patch was not given on 06/02/12 and 06/05/12 as ordered due to the medication was unavailable. The MAR indicated the resident received the fentanyl patch on June 7, 13, 14, 18, 20, 23, and 27, 2012.</p> <p>The Controlled Drug Use Record, indicated the fentanyl patch was signed out on June 13 and 14, 2012, June 17 and 18, 2012, June 20, 2012, June 22, 2012, June 25 and June 27, 2012, June 28, 2012, and June 30, 2012.</p>		<p>and reconciled, including Fentanyl patches.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>Resident #3 continues to receive pain relief through the use of a Fentanyl patch, 50mcg/hour, changed every three days.</p> <p>Resident #9 continues to receive pain relief through the use of a Fentanyl patch, 12mcg/hour changed every 3 days.</p> <p>Resident #22 continues to receive pain relief through use of a Fentanyl patch 12 mcg/hour changed every 3 days.</p> <p>The Director of Nursing will complete an inservice for nurses on 9/27/12 covering medication administration policies, including the process for administering all drugs as ordered by the physician, documenting controlled drugs and the need to count controlled drugs at the end of every shift, as well as to check the documentation of each on the "count" sheet for each drug. Nurses will also be instructed to place each count sheet in the individual resident's medical record when the form is completed.</p> <p>The nurses will also be inserviced on the pharmacy policy and procedure for obtaining</p>		

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	<p>The Nurses' notes indicated on 06/14/12 at 2:14 p.m. a new patch was applied, on 06/18/12 at 10:15 a.m. a new patch was applied, and on 06/19/12 at 11 a.m. the patch was intact.</p> <p>The MAR, dated 07/12, indicated the fentanyl patch was applied on July 4, 7, 10, 13, 16, 19, and 30, 2012. The MAR indicated the fentanyl patch was held not given due to being unavailable on July 22, 25, and 28, 2012. The MAR indicated the facility notified the pharmacy about the fentanyl patch on 07/25/12.</p> <p>The facility could not find a Controlled Drug Use Record for July.</p> <p>The Pharmacy shipping manifest indicated 10 patches of fentanyl were delivered on 06/11/12 and 9 patches were delivered to the facility on 06/30/12.</p> <p>During an interview on 08/30/12 at 9:10 a.m., the Director of Nursing (DoN) indicated she was told the patches were falling off all the time. She indicated two nurses should have destroyed the medications if it came off. She indicated there was nothing in the record to indicate the patches had come off early or where the other patch was. She indicated she did not know where the patches went.</p>		<p>prescriptions for Schedule II drugs so that those drugs can be sent for the residents in a timely manner. If the prescription is not obtained from the physician as quickly as needed, the nurses will be responsible to notify the physician of the unavailability of the medication. The nurses will notify the DON at that same time as to the unavailability of the medication and the lack of a physician's prescription.</p> <p>Following the inservice, all nurses will be tested to pass a medication administration competency test.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents receiving a narcotic patch for pain control have the potential to be affected. There have been no further identified concerns of narcotic pain patches being unavailable.</p> <p>In the future, if the DON finds an issue in regards to administration of medications, including not giving medications as ordered, medications being "unavailable", or not having accurate count sheets for controlled drugs, she will intercede immediately to make sure that the resident is receiving what he/she has been</p>				

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	<p>During an interview on 08/30/12 at 9:20 a.m., the Administrator indicated two of the nurses were no longer employed at the facility. She indicated she had been told the patches were rolling off the resident and they were applying new patches.</p> <p>2. Resident #9's record was reviewed on 08/30/12 at 5 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, left breast mastectomy, and seizures.</p> <p>The Physician's Recapitulation Orders, dated 06/12 and 08/12, indicated an order, originally dated 02/29/12 for fentanyl patch 12 mcg/hour, apply every three days.</p> <p>The MAR, dated 06/12, indicated the the fentanyl patch was applied on June 2, 5, 8, 11 and 14, 2012. The MAR indicated the patch was not given on June 17, 20, 23, 26, and 29, due to the medication was not available and the pharmacy was notified on 06/17/12.</p> <p>The Controlled Drug Use Record, indicated the fentanyl patch was signed out and given on June 5, 6, 8, 11, 13, and 14, 2012.</p> <p>A Nurses' Note, dated 06/14/12 at 1:15</p>		<p>ordered by the physician and will initiate a medication error sheet if indicated by the situation.</p> <p>Once that is done, she will investigate the situation fully and re-train the nurse(s) involved in the issue. She will also give progressive disciplinary action up to and including termination for any noncompliance related to medication administration</p> <p><u>3. What measures will be put into place to ensure that this practice does not recur?</u></p> <p>All licensed nurses will routinely complete a narcotic count between shifts and complete walking rounds to the room of each resident who has a Fentanyl patch ordered by the physician in order to visualize placement of the Fentanyl patch. The nurses will then sign on the medication administration record, indicating that the patch is present. The Director of Nursing now reviews the completed narcotic count sheet prior to placement in the residents' medical record.</p> <p>Pain assessments will be updated by 9/27/12 for all residents receiving a pain patch to ensure effectiveness. If there is any change in the pain assessment outcome, the physician will be notified.</p> <p>The Director of Nursing or</p>				

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	<p>p.m., indicated, "...Fentanyl patch remains on (R) (right) shoulder..."</p> <p>A Nurses' Note, dated 06/29/12 at 8 a.m., indicated, "Spoke c/ (with) (Physician's name) regarding order for Fentanyl Patch...will place order today..."</p> <p>The MAR, dated 07/12 indicated the fentanyl patch was applied on July 3, 6, 9, 12, 15, 18, 21, 27, and 30, 2012, which indicated the resident went from June 14, 2012 to July 3, 2012 without the fentanyl patch (missing five doses). The MAR indicated the fentanyl was not given as ordered on 07/24/12 due to the medication being unavailable.</p> <p>The facility could not find a Controlled Drug Use Record from 06/12/12 through 07/27/12.</p> <p>During an interview on 08/30/12 at 4:55 p.m., the Administrator indicated she did not know where the patches went and was unsure why the medication was not given. She indicated this was the second controlled count sheet that was missing.</p> <p>3. Resident #22's record was reviewed on 08/31/12 at 12:20 p.m. The resident's diagnoses included, but were not limited to, spinal stenosis, non-Hodgkin lymphoma, and dementia.</p>		<p>designee will complete an audit of the medication Administration record and the controlled drug count sheets three times a week for 30 days and then weekly for 30 days to ensure medications are given as scheduled. Any medications that have been circled indicating the medication was not given must have a detailed explanation on the reverse side of the medication administration record.</p> <p>A nurse, who circles a medication as not being given but fails to document the explanation, will receive retraining of the proper procedure and disciplinary action. If the DON or designee find any other issues, the DON will follow through with the nurse(s) involved as indicated in question #2.</p> <p>- 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- Results of the medication administration record and controlled drug count sheets audit will be reviewed at the monthly QA&A committee meeting for 60 days. Once 100% compliance is obtained the QA&A Committee may decide to stop the written audits; however, the checking of the DON or designee of the MARs and controlled drug sheets will continue on an ongoing basis.</p>		

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	<p>The Physician's Recapitulation Orders, dated 09/12, indicated an order for fentanyl patch 12 mcg/hour, apply one patch every three days.</p> <p>The MAR, dated 06/12, indicated the resident received the fentanyl on June 2, 5, 8, 11, 15, 18, 21, 24, and 30, 2012. The MAR indicated the fentanyl was not given on June 14 and 27, 2012, no reason documented.</p> <p>A Controlled Drug Use Record, indicated the fentanyl patch was signed out as given on June 15, 18, 20, 21, 24, 27, 29, 2012,</p> <p>The MAR, dated 07/12, indicated the resident received the patch on July 2, 4, 5, 7, 14, 16, 17, 20, 23, 26, and 29, 2012. The MAR indicated the patch was held on July 10 and 13, 2012 due to unavailable and the pharmacy was made aware on 07/10/12.</p> <p>A Controlled Drug Use Record, indicated the fentanyl patch was signed out as given July 2, 4, and 7, 2012.</p> <p>A Controlled Drug Use Record indicated the fentanyl patch was signed out as given on July 14, 17, 20, 23, 26, and 29, 2012.</p> <p>During an interview on 08/31/12 at 9:50</p>			

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	<p>a.m., the Administrator indicated it was the nurses' responsibility to ensure the medications were given and signed out as ordered. She indicated she had not realized the residents were not receiving the fentanyl patches as ordered. She indicated she looked at the Controlled Drug sign out form, but had not looked at the dates they were being signed out.</p> <p>A facility policy, dated 06/04, titled, "Medications-Controlled", received from the Administrator as current, indicated, "...1. all controlled drugs are counted immediately upon receipt from the pharmacy. 2. As each dose is administered, sign the drug inventory sheet specific to that resident with the date and time given to the resident...4. all doses shall be signed out upon use and the count kept current. 5. when a controlled drug is administered to a resident, it will also be documented on the resident's MAR..."</p> <p>3.1-25(m)</p>			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, record review and interview, the facility failed to follow</p>	F0441	F441 F441: Please indicate how often	10/04/2012			

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	<p>standard precautions during the performance of routine testing of blood glucose levels, related to disinfecting blood glucose monitors (checks blood sugars) during one observation of blood sugar monitoring for 1 of 1 resident observed for blood glucose testing in a sample of 10 (Resident #1) . In addition, the facility failed to ensure 2 of 3 nurses (LPN #1 and Minimum Data Set (MDS) Nurse) interviewed in the facility were knowledgeable of the disinfectant wipes instructions for cleaning the glucometer, and failed to ensure the facility's policy and procedure for disinfecting the blood glucose monitors followed the instructions of the disinfectant wipes used to clean the glucometer to prevent the transmission of blood borne pathogens. This had the potential to affect 5 residents who received blood glucose monitoring out of a total population of 21 in the facility.</p> <p>B. Based on observation, record review, and interview, the facility failed to ensure a sanitary environment to help prevent the development and transmission of disease and infection related to handwashing for 1 nursing staff feeding 2 residents during 1 of 3 meal observations. (Agency LPN #2, Residents #9 and #10)</p> <p>Findings include:</p>		<p>the random glucose meter sanitations observations will be conducted. Please indicate if all nursing staff who complete glucose meter testing will be observed. Random glucose meter sanitations observation will be conducted weekly for 30 days then as necessary. Each nurse will be monitored at least once per month and more frequently if issues are noted.</p> <p>It is the policy of this facility that practices are in place designed to provide a safe, sanitary, and comfortable environment and to help prevent the spread of disease and infection, including the sanitation of the blood glucose meters and appropriate handwashing. <u>1. What corrective action will be done by the facility?</u></p> <p>It should be noted that the prior procedure did have the meter wiped thoroughly with the Sani-Wipe so that the surface of the meter was wet and then allowed to air dry for 2 minutes. After conferring with the manufacturer, the policy was updated on 8/30/12 to wipe the meter as before, and then keep the Sani-Wipe wrapped around it to keep it moist for 2 minutes, before removing the wipe and air drying it. All the nurses were inserviced on 8/30/12 regarding the revised procedure before completing any other blood glucose procedures. On September 27, 2012 the Director of Nursing will review the blood</p>		

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	<p>A1. During an observation of a glucometer check on 08/29/12 at 4:20 p.m., the MDS Nurse indicated the glucometer was washed between each resident. The MDS Nurse then checked Resident #1's blood sugar, left the resident's room, used alcohol gel on her hands and then wiped the glucometer with a Sani-Cloth, then placed the glucometer in a basket in the medication cart. The MDS Nurse indicated she never timed the amount of time the glucometer stayed wet; she indicated she just wipes it down and then lets the glucometer air dry. During this observation, the glucometer did not stay wet for two minutes.</p> <p>Review of the Sani-Cloth disposable wipe instructions, at the time of the observation, the packet indicated, "...directions for use...unfold a clean wipe and thoroughly wet surface...must remain visibly wet for a full two (2) minutes..."</p> <p>During an interview on 08/29/12 at 5:35 p.m. the Director of Nursing indicated there were 4-5 residents in the facility who receive glucometer testing.</p> <p>During an interview on 08/30/12 at 11:30 a.m., LPN #1 indicated she wipes down the glucometer and lets the glucometer air dry. She indicated the glucometer does</p>		<p>glucose meter sanitation policy once again with all licensed nurses. Each nurse will then be checked off on the sanitation procedure. On September 27 th , the DON will re-train all nursing staff on handwashing technique, including proper hand sanitation while assisting residents during meal time. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents who routinely receive blood glucose checks have the potential to be affected. No residents were negatively affected. All residents have the potential to be affected by staff handwashing technique. If the DON, designee, or Administrator observes a nurse or QMA not following the blood glucose meter sanitation procedure, they will stop the staff member immediately. The DON or designee will retrain nurse/QMA at that time on the proper procedure for sanitizing the blood glucose meter. Once that is done, the staff member will perform a return demonstration of the proper procedure. Once the DON or designee is satisfied with the staff member's performance, the nurse/QMA will be allowed to continue with checking other residents' blood glucose. In addition to the retraining, the DON will render progressive disciplinary action for continued</p>		

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	<p>not stay wet for two minutes.</p> <p>The glucometer manufacturer's cleaning instructions, received from the Director of Nursing on 08/30/12 at 11:30 a.m., indicated, "...Cleaning and disinfecting can be completed by using the Super Sani-Cloth Germicidal Disposable Wipe...To use this produce, remove a wipe from the container and follow product label instructions..."</p> <p>A facility policy, dated 07/10, titled, "Diabetic Testing", received from the Administrator as current, indicated, "...Put gloves on and wipe the entire surface of glucose meter to disinfect it with the Sani-Cloth wipe. 4. Place the glucose meter on a clean surface and allow to air dry for 2 minutes..."</p> <p>During an interview on 08/30/12 at 11:30 a.m., the Director of Nursing indicated the facility policy has been changed to include the glucometer must stay visibly wet for two minutes.</p> <p>B1. During an observation of the evening meal on 08/29/12 at 5:15 p.m. through 5:30 p.m., Agency LPN #2 was sitting at the table feeding Resident #9 and #10 their supper.</p> <p>Agency LPN #2 asked another employee</p>		<p>noncompliance. If the Administrator or other department managers observe staff not using proper hand hygiene during meal service and when assisting residents with their meals, the staff will be stopped immediately and retrained on proper hand hygiene. They will be observed throughout that meal by the DON, Administrator, or manager present during the meal to make sure that they perform hand hygiene as per policy. They will also receive progressive disciplinary action for continued noncompliance. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> Random glucose meter sanitation observations will be conducted by the DON or designee at least weekly for the next 60 days to ensure proper procedure is followed. The DON, Administrator, and the department managers who assist in supervising resident meals will perform hand hygiene audits 3 times weekly at various meals for the next 30 days, then weekly for the following 30 days. Any identified concerns with either the glucose meter sanitation or hand hygiene during meals will be addressed as outlined in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the random glucose meter sanitation</p>				

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	<p>for assistance with repositioning Resident #9, they both touched the resident and repositioned the resident in her chair. Agency LPN #2 then sat down, without washing her hands, reached across Resident #10 and touched Resident #10's fork on the tines, then gave Resident #10 a bite of peaches. Agency LPN #2 continued to feed Residents #9 and #10.</p> <p>Agency LPN #2 then reposition Resident #9 again, then wiped Resident #9's chin with the clothing protector, held Resident #9's hand and gave her a drink with her hands touching the resident's straw close to the resident's mouth.</p> <p>Agency LPN #2, then gave Resident #10 a drink, touching her straw with her fingers, close to the resident's mouth. Agency LPN #2 then moved Resident #9's hands with her hand, gave the resident a drink, then turned to give Resident #10 a bite of peaches and another drink of water, while touching the resident's straw.</p> <p>Agency LPN #2 did not wash her hands with soap and water or alcohol gel through out the observation.</p> <p>During an interview on 08/30/12 at 6:15 p.m., the Administrator asked if Agency LPN #2 had used alcohol gel for handwashing.</p>		<p>check-offs to the monthly QA&A committee meeting for review and recommendations. The Administrator will bring the results of the hand hygiene audits to the monthly QA&A Committee meeting. After the 60 days has elapsed, the QA&A Committee may decide to stop the written audits when 100% compliance is obtained; however, the DON will continue to do random observations of the nurses/QMAs performing blood glucose sanitation, and the Administrator and department managers will continue to monitor hand hygiene during meal service on an ongoing basis.</p>				

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	<p>A facility policy, dated 07/10, and titled, "Handwashing/Alcohol-Based Hand Rub", received from the Administrator as current, indicated, "...personnel should always wash their hands (even when gloves are worn):...Before and after each resident contact; After touching a resident or handling his/her belongings..."</p> <p>3.1-18(j) 3.1-18(l) 3.1-19(g)</p>			

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F0520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to identify and implement plans of action to correct quality deficiencies related to pressure ulcers and skin assessments for 3 of 3 residents with pressure sores in a sample of 10. (Residents #3, #7, and #16)</p> <p>Findings include:</p> <p>1. During an observation on 08/31/12 at 10:10 a.m. with the Director of Nursing</p>	F0520	<p><u>F520</u></p> <p>- It is the policy of this facility identify and implement plans of action to correct quality deficiencies regarding resident services, including pressure ulcers and skin assessments.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>The former administrator has been replaced by an experienced long term care Administrator who</p>	10/04/2012

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	<p>(DoN) and the Corporate RN Consultant present, the DoN described Resident #16's right buttock/coccyx pressure ulcer as 3.5 centimeters (cm) by 3 cm. The DoN then indicated there was tunneling at 12 o'clock (area on the wound) and measured the tunneling with a paper measurement device at 0.1 cm, and the measured the depth of the rest of the wound at 0.5 cm. The DoN indicated that was all they had to measure depth of the wound. The Corporate RN Consultant indicated the depth needed to be measured with a Q-tip. The DoN then obtained a Q-tip and re-measured the tunnel area at 2.5 cm and the depth of the rest of the wound at 0.7 cm. The DoN described the wound as, "beefy red" and indicated the wound looked better than it did, "the other day."</p> <p>Resident #16's record was reviewed on 08/30/12 at 11 a.m. The resident's diagnoses included, but were not limited to, advanced dementia and hypertension.</p> <p>The resident's Quarterly Minimum Data Set Assessment (MDS), dated 07/17/12, indicated the resident was cognitively impaired, was totally dependent for all activities of daily living, was at risk for pressure ulcers, and did not have unhealed pressure ulcers.</p> <p>A care plan, dated 07/24/12, indicated the</p>		<p>is familiar with long term care operations, including the development of plans of action to address issues that have been identified by the interdisciplinary team and other agencies. The new Administrator will meet with her department managers and Medical Director by 10/4/12 to review the function of the Quality Assessment and Assurance Committee, including the identification of and development of action plans to correct quality deficiencies affecting resident care and services. As indicated throughout this 2567, the results of the various audits and monitoring activities that are being implemented to correct the deficiencies found during this survey will be incorporated into the Quality Assessment and Assurance activities of the Committee for review and recommendations for further process improvement. This will continue on an ongoing basis.</p> <p>Resident #3 and resident #9 do not currently have skin breakdown or open areas. Specific treatment orders have been received for preventative skin cream for resident #3 and #9.</p> <p>Resident # 16 is scheduled for a wound clinic evaluation on 9/20/12. The pressure area is assessed with each dressing change and routinely measured</p>		

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	<p>resident was at risk for skin breakdown. The interventions included, "...observe my skin daily and document on wkly (weekly) and prn (as needed)..."</p> <p>An "Assessment of Other Skin Abnormalities," dated 07/25/12, indicated the resident had an open area on the coccyx area which measured 1.5 cm x 0.5 cm.</p> <p>A weekly pressure ulcer assessment, dated 07/25/12, indicated the resident had an in-house acquired stage one (intact skin with non-blanchable redness) area on the right buttock, which measured 2 cm x 3 cm x less than 0.2 cm (depth) (stage two), and the current treatment was Kenalog cream (fungal cream).</p> <p>During an interview on 08/30/12 at 1:45 p.m., the Administrator indicated the area on the buttock was open and was not a stage one.</p> <p>A fax form to the physician indicated the resident had an open area on her buttock at 1.5 cm x 0.5 cm and a Duoderm (skin protection dressing) was applied, and an order was requested to continue the Duoderm daily until the area was healed.</p> <p>A physician's order, dated 7/27/12, indicated to apply a Duoderm to the open</p>		<p>by the Director of Nursing following facility policy/procedure. Treatment changes are recommended to the attending physician as needed including the referral to the wound clinic.</p> <p>- On 9/27/12, all licensed nurses will be inserviced by the Director of Nursing and the Nurse Consultant on the importance of preventative skin care and the facility policies and procedures for prevention, accurate assessment of wounds, using appropriate physician ordered medications and treatments for specific wounds, and the timely and accurate documentation of each. In addition, forms related to documentation of pressure sores and non-pressure sores, weekly skin assessments, and Braden assessments, and treatment administration will be reviewed.</p> <p>- <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>Head to toe skin assessments were completed for all residents on 8/31/12 and 9/1/12. There were no new wounds identified on any resident at that time.</p> <p>If the DON should find that the nursing staff has not followed through on any part of the pressure ulcer prevention,</p>				

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	<p>area until healed daily.</p> <p>The Treatment Administration Record (TAR) indicated on 07/27/12, an order was written to apply a Duoderm to the open area on the buttocks daily until healed. The TAR indicated a Duoderm was applied on 07/27/12.</p> <p>The TARs dated 07/12 and 08/12 lacked documentation to indicate the Duoderm had been removed or changed.</p> <p>The Nurses' Notes indicated: 07/28/12 at 1:30 a.m.-"Duoderm intact..." 07/29/12 at 2:30 a.m.-"Intact duoderm to buttock..." 07/31/12 at 1:50 a.m.- "checked resident duoderm intact..." 08/01/12 at 4:40 p.m.- "New Duoderm applied, area to coccyx remains open. Tender to touch" 08/02/12 at 1:50 a.m.-"Duoderm intact to coccyx..." 08/03/12 at 4:25 p.m., "Cream applied to coccyx area. Remains tender to touch..." 08/04/12 at 2:45 a.m., "Coccyx area remains tender to the touch..." 08/04/12 at 8:45 p.m., "Coccyx area continues to be tender to the touch..." 08/05/12 at 4:30 a.m., "Coccyx area tender to touch..." 08/05/12 at 9:30 p.m., "Coccyx area tender to touch..."</p>		<p>treatment, or documentation systems, she will intercede immediately to make sure that the resident is being appropriately cared for. When that is done, she will re-train the nursing staff involved regarding the policy and procedure for the part of the skin system that the DON identified as lacking. She will also render progressive disciplinary action up to and including termination for continued noncompliance with any part of the skin/wound systems.</p> <p><u>3.What measures will be put into place to ensure that this practice does not recur?</u></p> <p>- Preventative skin care is completed routinely for all resident.All residents have pressure relieving devices on beds and in wheelchairs or other seating such as recliners. Weekly head to toe skin assessments are completed along with the weekly summaries.</p> <p>A new weekly summary/weekly skin assessment "schedule board" is now in place in the nurses' station to remind the nurses when scheduled assessments are due.</p> <p>Braden assessments will be updated for all residents prior to 9/27/12 to make sure that staff is aware of the level of the residents' current skin risk for</p>				

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	<p>08/06/12 at 9:40 p.m., "Coccyx area continues to be tender to touch..."</p> <p>08/07/12 at 8:25 p.m., "Coccyx remains tender to the touch..."</p> <p>08/10/12 at 2:55 p.m., "Coccyx remains tender to touch..."</p> <p>08/11/12 at 1:40 a.m., "...Coccyx tender to touch and open...0/ (no) duoderm open to air..."</p> <p>The physician's order lacked documentation to indicate the duoderm had been discontinued.</p> <p>The Nurses' Notes indicated: 08/13/12 at 8 p.m., "Coccyx remains tender to touch..."</p> <p>08/14/12 at 1:30 p.m., "...Skin assessment done. Skin on (R) (right) buttock cheek (sic) 3 cm x 2 cm open area Tender to touch...Hard area noted around area on (R) buttock. DON (Director of Nursing) notified and aware..."</p> <p>08/14/12 at 4 p.m., "Rec'd (received) order from (Physician's Name) to use bioclusive (transparent dressing)...."</p> <p>The Nurses' Notes indicated the Duoderm had not been changed, and the open area was not assessed for description of the area after 08/02/12.</p> <p>The weekly pressure ulcer assessment indicated after 07/25/12 the next</p>		<p>development of pressure ulcers and that the appropriate interventions are in place for prevention and treatment of skin issues.</p> <p>Braden skin assessments are completed routinely for all residents at the time of admission, quarterly with the MDS and with a change in resident condition. Those residents with a Braden score <17 are considered high risk and a care plan has been developed. In addition, a resident who is incontinent of bowel or bladder and residents who have decreased mobility are routinely care planned for being at risk for skin breakdown.</p> <p>The skin prevention program includes weekly skin assessments, completion of shower sheets by direct care staff to alert nursing supervisors of possible skin concerns and pressure relieving devices and preventative skin creams/ointments. Pressure areas are assessed with each dressing change and routinely by the Director of Nursing following facility policy. Pressure areas are measured weekly by the Director of Nursing, the information is recorded and forwarded to the Administrator, as well as the Nurse Consultant and Director of Clinical Services for review. If the wound has not</p>	

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	<p>assessment of the open area was 08/17/12 (three weeks later), which indicated the area was now a stage three, with measurements of 3 cm x 3.5 cm with a 0.2 cm of depth, had no tunneling or undermining, and had moderate amount of exudate.</p> <p>The weekly pressure ulcer assessment indicated the next assessment of the open area was 08/29/12 (12 days later) and the area continued to be a stage three, measurements were 3 cm x 4.53 cm with less than 0.5 cm depth, had tunneling less than .02, moderate amount and the last treatment change was 08/15/12, which was Calcium Alginate (wound dressing).</p> <p>The Nurses' Noted lacked documentation the physician had been notified of the buttock area being tender to touch. There was a lack of documentation to indicate the physician had been updated on the area until the area became a stage three. There was a lack of documentation to indicate the physician had been notified when the tunnel area had been found in the open area.</p> <p>There was a lack of documentation on the weekly pressure ulcer assessment to describe the color and odor of the exudate.</p>		<p>shown improvement for 2 weeks, the need for treatment change is addressed with the physician at that time.</p> <p>The Director of Nursing or Designee will review the focused charting, the 24 hour condition change report, and physician orders at least 5 days each week. The review will be completed just prior to the morning meeting. Any change of resident condition, including skin condition, will be reviewed by the Interdisciplinary team during the morning meeting ensuring that physician notifications are completed, documented appropriately, and transcribed to the resident's treatment administration record (TAR).</p> <p>The resident's care plan will be updated at that time with any new orders and interventions. When the meeting is done, the DON will note any new interventions on the 24 hour report sheet so that subsequent shifts are aware of any changes. The DON will also update the CNA assignment sheets with the new interventions.</p> <p>The Director of Nursing or designee will audit weekly skin assessments and weekly summaries for completion 3 times weekly for 30 days, then weekly for another 30 days to ensure completion and accuracy. Identified issues will be dealt with</p>		

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	<p>During an interview on 08/30/12 at 11:40 a.m., the DoN indicated the nurses are supposed to be monitoring, assessing, and measuring the open areas weekly. She indicated the resident's open area started as a shearing. She indicated she was unsure if the area had been measured from 07/25/12 through 08/17/12.</p> <p>During an interview on 08/30/12 at 1:50 p.m., the Administrator indicated the area was a shear from the sheet, not a pressure area.</p> <p>2. During an observation on 08/30/12 at 3:35 p.m., with the DoN present, Resident #3's coccyx area had no open area. The area was described by the DoN as newly healed, pink, with fresh scar tissue.</p> <p>Resident #3's record was reviewed on 08/29/12 at 4 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and macular degeneration.</p> <p>The Significant Change MDS assessment, dated 05/23/12, indicated the resident had cognitive impairment, required extensive assistance for bed mobility and transfers, was always incontinent of urine, was at risk for pressure ulcers, and had no unhealed pressure ulcers.</p>		<p>as outlined in question #2.</p> <p>- 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The DON will bring the results of her reviews of the focus charting, 24 hour report, and physician orders related to residents' changing skin condition, as well as her audits of the weekly skin assessments and weekly summaries to the monthly QA&A committee meeting for review and recommendation for the next 60 days. Once that time period is completed, the QA Committee may decide to discontinue the written audits when 100% compliance has been achieved. However, the DON's review of the focus charting, 24 hour report, physician orders and skin conditions, and weekly summaries and skin assessments will continue on an ongoing basis.</p>				

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	<p>The Physician's Recapitulation Orders, dated 07/12, indicated an order, dated 06/22/12, for Duoderm to reddened area on buttocks, change every three days.</p> <p>A Nurses' Note, dated 06/22/12 at 9:45 p.m., indicated, "Duoderm applied to area on buttocks...Area measures 0.5 cm x 1 cm. Area next to it measures 1 cm x 1.5 cm (R) lower (arrow down) buttocks. Resident states she has been itching it..." The Nurses' Note lacked documentation to indicate a description of the area.</p> <p>The Nurses' Notes, dated 06/23/12 at 12:15 p.m. through 08/07/12 at 1:30 p.m., indicated the treatment continued and the Duoderm was intact.</p> <p>A Nurses' Note, dated 08/07 12 at 1:30 p.m., indicated the open areas to the coccyx remained.</p> <p>A Nurses' Note, dated 08/09/12 at 1:30 p.m., indicated the open area to the coccyx remained.</p> <p>A Nurses' Note, dated 08/15/12 at 11 p.m., indicated the open area to the coccyx was close to healing.</p> <p>A Nurses' Note, dated 08/20/12 at 10 p.m., indicated the Duoderm on the coccyx area was intact.</p>			

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	<p>There was a lack of documentation after 08/20/12 to indicate the area on the coccyx had been observed and assessed.</p> <p>There was a lack of documentation the area on the buttock had been assessed after it was found on 06/22/12 until the weekly summary, dated 07/13/12, which indicated the area was a red scabbed area.</p> <p>During an interview on 08/30/12 at 11:40 a.m., the DoN indicated she could not find a weekly skin assessment for the resident.</p> <p>3. Resident #9's record was reviewed on 08/30/12 at 5 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and seizures.</p> <p>The Annual MDS Assessment, dated 07/03/12, indicated the resident's cognition was impaired, required extensive assistance with bed mobility and transfers, was a risk for pressure ulcers, and had no unhealed pressure ulcers.</p> <p>A care plan, dated 07/10/12, indicated the resident was at risk for skin breakdown. The interventions included to observe the resident's skin daily for open areas and document weekly and as needed.</p>			

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	<p>A weekly skin assessment, dated 08/07/12, indicated the resident had an abrasion to the right buttock which was from shearing.</p> <p>A fax form, dated 08/13/12 at 12:40 p.m., indicated the resident had an open area 1 cm x 0.5 cm on the right buttock and requested a of Duoderm.</p> <p>A Physician's Telephone Order, dated 08/14/12, indicated an order for Duoderm to the buttock every three days or as needed.</p> <p>The Nurses' Notes indicated: 08/13/12 at 8 p.m., "...Duoderm to (R) buttock remains..." 08/14/12 at 1:45 a.m., "...Duoderm applied to coccyx...due to removal c/ (with) brief change..." 08/15/12 at 2 a.m., "...Duoderm intact to coccyx area..." 08/30/12 at 10:35 a.m., "...Duoderm intact to (R) buttock area..."</p> <p>The record lacked documentation to indicate the open area on the right buttock had been thoroughly assessed when found and assessed after 08/13/12.</p> <p>During an interview on 08/31/12, the Corporate RN Nurse Consultant indicated</p>			

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	<p>the weekly head to toe assessments of the residents had not been getting done. The Administrator indicated skin issues are discussed in morning meetings, and she was unaware of the area on Resident #9, and was unsure if she was aware of the area on Resident #3. The Administrator indicated if the nurses were doing the skin assessments like they were supposed to, she would have known about the areas.</p> <p>A facility policy, dated 06/04, titled, "Skin Assessments", received from the Administrator as current, indicated, "...The Director of Nursing or designated nurse will do weekly skin assessments on all residents...1. Head to toe assessments will be done weekly...Documentation of these skin assessments will be completed, using the 'Weekly Head-To-Toe Skin Assessment' form..."</p> <p>During an interview on 08/31/12 at 9:50 a.m., the Corporate RN Nurse Consultant indicated the weekly head to toe assessments of the residents had not been getting done.</p> <p>4. During an interview on 08/31/12 at 9:50 a.m., the Administrator indicated the facility had not been including pressure areas/skin issues in Quality Assurance meetings. She indicated skin issues would not be talked about unless the</p>			

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	<p>Department Head identifies a problem/concern . She indicated if skin issues are present, are discussed in morning meetings, and she was unaware of the area on Resident #9. and was unsure if she was aware of the area on Resident #3. The Administrator indicated if the nurses were doing the skin assessments like they were supposed to, she would have known about the areas. She indicated there were systems in place, but they were not utilized.</p> <p>3.1-52(b)(2)</p>			