

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
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NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 5, 6, 7, 8, 11, and 12, 2014</p> <p>Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100</p> <p>Survey Team: Pamela Williams, RN - TL Julie Baumgartner, RN Shauna Carlson, RN ( 8/5, 8/6, 8/7, 8/11, 8/12, 2014) Sharon Ewing, RN</p> <p>Census bed type: SNF: 7 SNF/NF: 124 Total: 131</p> <p>Census payor type: Medicare: 22 Medicaid: 86 Other: 23 Total: 131</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>9/2/14 – To Whom It May Concern:</p> <p>One August 5 -12, 2014 a health survey was conducted at East Lake Nursing &amp; Rehabilitation. Attached is the plan of correction, the creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.</p> <p>Thank you for your time and consideration, Martin Lebbin Executive Director East Lake Nursing and Rehabilitation</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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F000157 SS=D	<p>Quality Review completed on August 21, 2014, by Brenda Meredith, R.N.</p> <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>			
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	<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 observation, interview and record review, the facility failed to notify the residents responsible party regarding changes in medications and lab tests for 1 of 1 residents reviewed for notification. (Resident #107)</p> <p>Findings include:</p> <p>During an interview on 8/7/14 at 10:00 A.M., Resident #107 husband indicated he had not be notified that Resident #107's anticoagulant medication (Coumadin/Warfarin) had been changed and her lab tests stopped.</p> <p>On 8/8/14 at 9:10 A.M., Resident #107's clinical record was reviewed. A physicians order, dated 8/4/14, indicated "DC [discontinue] Warfarin 3 mg [milligrams], start Eliquis [blood thinner] 2.5 mg PO [oral] BID [twice daily]." A physicians order, dated 8/5/14, indicated "DC PT/INR [Prothombin Time/ International Normalized Ratio] Coumadin DC' D [discontinued]."</p> <p>Review of the the nurses progress notes and events dated 8/4/14 -8/8/14 found no documentation of notification of change of medication to Resident #107's</p>	F000157	<p><b>F157 – Notify of changes (injury/decline/room, etc)</b></p> <p>It is the practice of this provider to notify the resident’s responsible party regarding changes in condition including changes in medication and lab orders.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident #107 responsible party has been notified of medication change and change in lab orders. The resident did not experience any negative outcomes related to the deficient practice as the physician order was the same acting agent for the same disease diagnosis.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding. The nurse management team /medical records nurse will audit all physician orders the next business day or sooner to ensure compliance with appropriate notifications.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p>	09/11/2014			

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	<p>husband.</p> <p>During an interview on 8/8/14 at 11:55 A.M., LPN #3 indicated that when medications are changed family is notified and then it is documented in either the progress notes or under events in the computer.</p> <p>During an interview on 8/8/14 at 1:50 P.M., the Nurse Consultant indicated that when a medication is changed "... family should be notified right away, not a day or two later and it should be documented under events."</p> <p>On 8/8/14 at 2:14 P.M., the Corporate Nurse reviewed the progress notes and the events in the computer and indicated there was no documentation that Resident #107's husband was notified of the anticoagulation medication change on 8/4/14.</p> <p>On 8/8/14 at 2:15 P.M., a review of the policy "Resident Change of Condition," dated March 2010, provided by the Corporate Nurse, indicated "... B. The nurse in charged is responsible for notification of physician and family/ responsible party prior to end of assigned shift... C. If unable to reach the physician or family/ responsible party... will be documented in the clinical record... F. ...</p>		<p>Audits will be on-going for all new orders to ensure proper responsible party notification has taken place. In-service will be provided, be the Clinical Education Coordinator/designee by 9/11/14, for all licensed nursing staff and will include a review of the policy titled "Change in condition". This in-service will also include review of company's expectation on documentation of notification in the residents medical record. To ensure proper responsible party notification has occurred the nurse management team/medical records nurse will audit all new orders.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI tool titled, "Change of Condition" daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p>				

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F000166 SS=D	<p>Documentation will include time and family/ physician response...."</p> <p>3.1-5(a)(3)</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to follow their policy for the resolution of grievances. This deficient practice affected 2 of 30 grievances reviewed. (Resident # 121 and Resident #100).</p> <p>Findings include:</p> <p>On 8/12/14 at 10:00 A.M., a form titled Resident/Family Concern/Grievance Form was reviewed for Resident #121. The date received was documented as 7/10/14 The nature of the concern was "... 4. Ice water is not passed in between meals...Section III: Name of individual contacted was [Resident's Name]</p>	F000166	<p><b>F166 – Right to prompt efforts to resolve grievances</b> It is the practice of this provider to promptly resolve resident grievances. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #100 and 121 had their grievances forms reviewed and addressed. The residents did not experience any negative outcomes related to the deficient concern. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential to be affected by this finding. The Customer Care Coordinator/Social</p>	09/11/2014			

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	<p>Comments: Ice water still not always passed...." The date concern and grievance resolved was signed and dated by the Executive Director on 7/20/14, 10 days after the concern was received.</p> <p>On 8/12/14 at 10:05 A.M., a form titled Resident/Family Concern/Grievance Form was reviewed for Resident # 100. The date the concern was received was documented as 7/10/14 and date of follow up with Resident # 100 was documented as 7/21/14, 11 days after the concern was received.</p> <p>On 8/12/14 at 11:17 A.M., an updated policy provided by the Director of Nurses titled " Resident Concerns and Grievances " was reviewed. The policy indicated the following: "...related to "... Ice water is something we always seem to have an issue with...." Procedure: Responses, appropriate plan/resolution to all complaints, and follow up with resident and or family will be made within 72 hours....The Executive director will sign off on all completed concerns/grievance forms, ensuring resident and/or family satisfaction.</p> <p>During an interview on 8/12/14 at 2:38 P.M., the Director of Nurses indicated we *(management) review grievances during</p>		<p>Services/Designee audited all resident/family concern/Grievance forms and identified a resolution within 72 hours per policy and procedure.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>On 8/11/2014 the Customer Care Coordinator and Social Services were re-educated on the "Resident Concerns and Grievances" policy, by the Executive Director.</p> <p>Facility will utilize a "Resident/Family Concern/Grievance log to monitor grievances and to ensure the 72 hour resolution time is maintained. The Executive Director/designee will review the Resident/Family Concern/Grievance log to ensure compliance for time frames.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>On 8/11/2014 the Customer Care Coordinator and Social Services were re-educated on the "Resident Concerns and Grievances" policy, by the Executive Director.</p> <p>Facility will utilize a "Resident/Family Concern/Grievance Log" to monitor grievances and to ensure the 72 hour resolution time is maintained. If concerns are noted the Executive Director/Designee will be notified</p>		

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F000226 SS=D	<p>the morning meeting. Follow up must be made with the individual or Resident who filed the concern.</p> <p>During an interview on 8/12/14 at 2:38 P.M., the Executive Director indicated he signed Resident # 121's grievance as resolved related to "... Ice water is something we always have an issue with."</p> <p>3.1-7 (a)(2)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p>		<p>immediately for corrective action. Executive Director will review the Resident/Family Concern/Grievance Log to ensure it is completed timely, appropriately and resolutions are resolved in the 72 hour time frame. To ensure ongoing compliance with this corrective action, the Executive Director/designee will be responsible for completion of the CQI tool titled, "Resident/Family Concern/Grievance Log" daily for 2 weeks, weekly for 2 weeks, bi-weekly for 2 weeks and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p>		

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	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure staff were knowledgeable related to what constitutes abuse for 4 of 8 employees interviewed for abuse. (ADON, CNA #2, LPN #3, CNA #5)</p> <p>Findings include:</p> <p>During an interview on 8-12-14 at 10:20 A.M., the ADON (Assistant Director of Nursing) indicated "...verbal, physical, mental, financial, seclusion, not observing their rights, not involving them in their plan of care...." as the different types of abuse.</p> <p>During an interview on 8-12-14 at 10:37 A.M., CNA (Certified Nursing Assistant) #2 indicated "...verbal, mental, sexual, physical, neglect...." as the different types of abuse.</p> <p>During an interview on 8-12-14 at 10:46 A.M., LPN (Licensed Practical Nurse) #3 indicated "...mental, sexual, misappropriation of funds, dignity, verbal, physical...." as the different types of abuse.</p>	F000226	<p><b>F226 – Develop/implement abuse/neglect, etc policies</b></p> <p>It is the practice of this provider to develop and implement written policies and procedure that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Staff will be re-educated on the 7 types of abuse by the Clinical Education Coordinator/designee by 9/11/14.</p> <p>Residents did not experience any negative outcomes related to the deficient concern.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding. The Clinical Education Coordinator will re-educate staff on the 7 types of abuse by 9/11/14.</p> <p>All new staff will be educated on the 7 types of abuse during orientation</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p>	09/11/2014			

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	<p>During an interview on 8-12-14 at 11:05 A.M., CNA #5 indicated "physical, isolation, mental, financial, sexual...." as the different types of abuse.</p> <p>During an interview on 8-12-14 at 1:55 P.M., the CEC (Clinical Education Coordinator) indicated the "...7 types of abuse are verbal, involuntary seclusion, physical, mental, neglect, misappropriation of funds, and sexual...staff should know all 7...."</p> <p>On 8-12-14 at 2:30 P.M., review of the Abuse Prohibition, Reporting, and Investigation policy and procedure, last updated October 2013, received from the Executive Director on 8-5-14 at 12:42 P.M., indicated "...It is the policy of [Corporation Name] protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...3. Employees whether direct care, contract staff, ancillary departments, volunteers, or consultants receive instruction/training on abuse during orientation and periodically during ongoing inservice education. The training will include:...what constitutes abuse...."</p> <p>3.1-28(a)</p>		<p>Re-education will be on-going for all staff to ensure knowledge of the 7 types of abuse.</p> <p>All staff will receive a "name tag" reminder that can be referred to if needed.</p> <p>The Executive Director/designee will question staff on all 3 shifts regarding knowledge of the 7 types of abuse.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>To ensure ongoing compliance with this corrective action, the Clinical Education Coordinator/designee will be responsible for completion of re-education.</p> <p>The Clinical Education Coordinator will re-educate staff on the 7 types of abuse.</p> <p>All new staff will be educated on the 7 types of abuse during orientation. If concerns are noted the Executive Director/Designee will be notified immediately for corrective action.</p> <p>To ensure ongoing compliance with this corrective action, the Executive Director/designee will be responsible for completion of the CQI tool titled, "Abuse – Staff Interview" daily for 2 weeks, weekly for 2 weeks, bi-weekly for 2 weeks and monthly for six months. If threshold of 100% is not met, an action plan will be developed.</p> <p>Findings will be submitted to the CQI Committee for review and follow up.</p>				

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure privacy and dignity was provided for 2 of 2 residents. (Resident #65 and #107)</p> <p>Findings included:</p> <p>On 8-11-2014 at 3:34 P.M., RN (Registered Nurse) #15 was observed opening the door to Resident #65's room and walking in without knocking or announcing herself. Interview at this time with RN #15 indicated, "...I usually do [knock] before I enter a room...I usually wait to be invited in [by the resident]...I'm not sure why I didn't...."</p> <p>On 8-12-2014 at 2:00 P.M., CNA (Certified Nursing Assistant) #16 and CNA #17 were observed entering Resident #107's room without knocking. An interview with CNA #16, at this time, indicated, "...we are supposed to knock and wait to be asked into a room...I don't</p>	F000241	<p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p> <p><b>F241 – Dignity and respect of individuality</b></p> <p>It is the practice of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Staff were immediately re-educated with return demonstration on how to enter a residents room by the staff educator. An all nursing staff in-service related to "how to enter a residents room" will be conducted. Resident # 65 and 107 are now afforded privacy by staff knocking on their door and receiving permission to enter.</p> <p>Resident # 65 and 107 experienced no negative outcomes related to this finding.</p> <p><b>How other residents having the potential to be affected by the</b></p>	09/11/2014
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	<p>know why we did not do that...."</p> <p>On 8-12-2014 at 2:30 P.M., record review of the Preceptor Checklist received at this time from the CEC (Clinical Education Coordinator) indicated, "...How to enter resident room...Knock before entering...State who you are before entering...State your purpose for coming into their room...." Interview at this time with the CEC indicated, "...it is my expectation that staff knock and wait to be invited into a resident room...."</p> <p>3.1-3(t)</p>		<p><b>same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding. The Clinical Education Coordinator will re-educate staff on how to enter a resident's room by 9/11/14. All new staff will be educated on the proper way to enter a resident's room during orientation.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The Clinical Education Coordinator will re-educate staff on how to enter a resident's room. All new staff will be educated on the proper way to enter a resident's room during orientation. If it is identified staff need further training and education, it will be provided on a one-to-one basis. The Clinical Education Coordinator/designee will conduct random audits to ensure compliance with the proper way to enter a resident's room. The Executive Director/designee will conduct rounds on all 3 shifts to ensure staff are knocking on doors and receiving permission prior to entry.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>To ensure ongoing compliance with</p>		

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F000243 SS=E	<p>483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP</p> <p>A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>Based on interview and record review, the facility failed to provide privacy during the Resident Council meetings. This affected 3 of 6 residents interviewed. (Resident #65, #72, and #113)</p>	F000243	<p>this corrective action, the Executive Director/designee will conduct rounds on all 3 shifts to ensure staff are knocking on doors and receiving permission prior to entry. Audits will be completed daily for 2 weeks, weekly for 2 weeks, bi-weekly for 2 weeks and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow-up</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p> <p><b>F243 – Right to participate in resident/family group</b></p> <p>It is the practice of this provider to allow residents the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a</p>	09/11/2014	

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	<p>Findings included:</p> <p>During an interview on 8-12-2014 at 9:10 A.M., Resident #65 indicated, "...I am the Resident Council president...I am not sure why he [Administrator] is there...he just comes...I left the one meeting in tears because he doesn't listen to our complaints...others don't want to speak up when he is there...."</p> <p>During an interview on 8-12-2014 at 9:22 A.M., Resident #72 indicated, "...I am not sure why he [Administrator] is there...I go to all of the Resident Council meetings...I don't mind him being there but I know that others don't want to talk during the meetings now...."</p> <p>During an interview on 8-12-2014 at 9:27 A.M., Resident # 113 indicated, "...I go to the Resident Council meetings...yes, the Administrator is there...I don't really like it...I don't know why he is there, he has been there for at least the last 4 times...."</p> <p>During an interview on 8-12-2014 at 10:30 A.M., interview with Activities Director indicated, "...He [Administrator] has had an open invitation since March to come to the Resident Council meetings...we address his open invitation sometimes...." Review of the minutes for the Resident Council meetings, at this</p>		<p>resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #65, 72, and 113 will be allowed to meet at the resident council without the Executive Director in attendance. Residents #65, 72, and 113 did not experience any negative outcomes related to the deficient concern.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential to be affected by this finding. The Activities Director will talk to the Resident Council President prior to each monthly meeting and receive a request for the Executive Director to attend the Resident Council Meeting.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> A form will be signed, by the Resident Council President, indicating if the Resident Council</p>				

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	time, showed no documentation indicating the open invitation was discussed.  3.1-3(j)		would like the Executive Director to attend the next monthly meeting. The Executive Director will only attend the Resident Council Committee Meeting with permission from the Resident Council. The Executive Director will be sensitive to the needs of the Resident Council and will excuse himself, when the council does not have any questions or concerns to share with him. This will allow the council to continue meeting without the Executive Director. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b> Each month the Activities Director will talk to the Resident Council President prior to each monthly meeting and receive a request for the Executive Director to attend the Resident Council Meeting. The form will be attached to the monthly resident council meeting minutes. If concerns are noted the Executive Director/Designee will be notified immediately for corrective action. Executive Director will review the resident council minutes, monthly, and make sure the request for the Executive Directors attendance form is attached. <b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow the care plan for 1 of 19 residents reviewed related to keeping his call light within reach. (Resident #162)</p> <p>Findings include:</p> <p>On 8-7-14 at 10:35 A.M., an observation of Resident #162's room was made. His call light soft touch pad was hanging clipped to the wall behind his bed.</p> <p>Interview with Resident #162 at this time indicated "...they hang it like that every day...I can't reach it...if I need to turn it on I have to use my reacher [assistive device] over my bed...It's irritating...."</p> <p>On 8-7-14 at 1:30 P.M., the clinical record for Resident #162 was reviewed. The MDS (Minimum Data Set) assessment for Resident #162, dated 6-14-14, indicated a BIMS (Brief Interview for Mental Status- cognition assessment) score of 12 out of a possible 15, indicating minimal deficit. Resident #162's medical record indicated diagnoses included, but were not limited</p>	F000282	<p><b>F282 – Services by qualified persons/per care plan</b></p> <p>It is the practice of this provider to follow the written plan of care for each individual resident.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident # 162 was immediately interviewed to assess his preference to call light placement. Resident # 162 now has the call light clipped to the bed. Individual care plan related to call light placement has been updated. The resident did not experience any negative outcomes related to the deficient practice. A facility audit was completed for call light placement. No other residents were affected.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding, but none were affected. The IDT team will review care plans on admission, annually, with each significant change and quarterly per the MDS schedule. Care plans will be</p>	09/11/2014			

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	<p>to, "...malnutrition, neurogenic bladder, multiple sclerosis [autoimmune nerve disease - confining him to his wheelchair]...."</p> <p>The "Falls" care plan, dated 12/17/13, indicated "...Resident is at risk for fall due to impaired mobility, dx [diagnosis] of anemia, multiple sclerosis, depression. Unsteady balance during transfers...Approach:... Call light in reach...."</p> <p>On 8-8-14 at 11:57 A.M., Resident #162's call light was observed to be clipped to the wall behind his bed.</p> <p>On 8-11-14 at 3:10 P.M., Resident #162's call light was observed to be clipped to the wall behind his bed. Interview at this time with the ADON (Assistant Director of Nursing) indicated it was her expectation "...the call light should be in reach of the resident...I do not know if he can reach it there from his wheelchair or not...."</p> <p>On 8-11-14 at 4:20 P.M., review of the CQI (Continuous Quality Improvement) for "Call Lights", used by the facility to train their staff, received from the DON (Director of Nursing) at this time, indicated "...The call light is within reach of the resident...There are clips attached</p>		<p>reviewed to ensure resident preferences for placement of their call lights are included in the plan of care.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Staff will be in-serviced regarding call light placement per resident preference. The Continuing Education Coordinator/designee will provide training by 9/11/14. The DNS/designee will review the care plan audits quarterly and with significant change.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b> The DNS/designee will conduct rounds on all shifts to ensure call lights are placed per resident preferences per plan of care. To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI tool titled, "Care Plan Updating" daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic changes will be completed:</b> Compliance date: 9/11/14</p>				

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F000323 SS=E	<p>to call light cord to ensure it will stay within reach of the resident...."</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, facility failed to ensure a safe environment related to hot water temperatures affecting 1 of 2 units. (Unit 1)</p> <p>Findings include:</p> <p>On 8/5/14 at 11:30 A.M., an observation made with the Maintenance Supervisor and the DON (Director of Nursing) of the 200 hall shower room indicated the hot water temperature was 122 degrees. An interview with the Maintenance Supervisor at this time indicated "... water temperature should not be greater than 120 degrees...."</p>	F000323	<p><b>F323 – Free of accident hazards/supervision/devices</b></p> <p>It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Water temps will be taken and logged to ensure temperatures are maintained between 100 and 120 degrees.</p> <p>Water temps are checked and appropriate on Unit 1.</p> <p>Residents did not experience any negative outcomes related to the</p>	09/11/2014			

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	<p>On 8/6/14 at 10:27 A.M., a environmental tour was conducted with the Maintenance Supervisor during the tour the following was observed: the hot water in Room 204 was 123.5 degrees, the hot water in the 200 hall shower room was 123 degrees, and the hot water in Room 215 was 121.6 degrees.</p> <p>During an interview on 8/6/14 at 10:45 A.M., the Maintenance Supervisor indicated that he never has calibrated the thermometer that he uses for temping the water. He further indicated that he checks the water temperatures once a week and had not yet checked the hot water temperatures this morning prior to the environmental tour.</p> <p>On 8/11/14 at 10:31 A.M., a review of the "Daily Water Temperature log" indicated that on 8/5/14 200 hall shower room hot water temperature was 122 degrees and initialed by the Maintenance Supervisor and on 8/6/14 unit 2 shower room hot water temperature was 129 degrees and initialed by the Maintenance Supervisor.</p> <p>On 8/12/14 at 2:10 P.M., the Maintenance Supervisor provided the form "Daily Water Temperatures" and he indicated that they do not have a current</p>		<p>deficient concern.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected.</p> <p>Water temps will be monitored throughout the facility, by the Maintenance Supervisor/designee and reviewed by the ED to ensure water temperature remains below 120 degrees.</p> <p>The Maintenance Supervisor/designee will monitor water temperatures and log water temperatures to ensure appropriate temperatures are maintained below 120 degrees.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>On 8/11/2014 Maintenance Supervisor was re-educated on water temperatures, water temperature monitoring and thermometer calibration, by the Executive Director.</p> <p>The Maintenance Supervisor/designee will monitor water temperatures in all resident areas and log water temperatures to ensure appropriate temperatures are maintained.</p> <p>If concerns are noted, Maintenance Supervisor/Executive Director/Designee will be notified immediately for corrective action.</p>				

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F000328 SS=D	<p>policy on water temperatures and this was what they went by.</p> <p>On 8/12/14 at 2:15 P.M., a review of the form "Daily Water Temperatures" indicated "... Water temperatures should be taken daily....Temperatures between 100-120 should be maintained in Resident care areas...."</p> <p>3.1-45(a)(1)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:</p>		<p>Executive Director will review temperature log to ensure they are completed timely, appropriately and temperatures are in range.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>Maintenance Supervisor/Executive Director/Designee will be auditing the water temperatures in all resident care areas and documenting the water temperatures on the water temperature log.</p> <p>The safety committee will review the audits and action plans will be developed, as needed, to ensure no issues arise from water temperatures being outside of guidelines.</p> <p>Audits of the temperature log will be completed by the Executive Director/Designee weekly for 4 weeks, then monthly ongoing. Audit results will be documented on the water temperature log.</p> <p>Threshold of 100% will be maintained or actions plans will be developed.</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p>	

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	<p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure nebulizer inhalation treatments were being given under the supervision of licensed staff for 1 of 1 residents reviewed for respiratory treatments. (Resident #10)</p> <p>Findings include:</p> <p>On 8-5-2014 at 12:06 P.M., Resident #10 was observed alone in her room with a nebulizer treatment in progress. Interview at this time with Resident #10 indicated "...I always do my own treatments [nebulizer inhalation]...."</p> <p>On 8-5-2014 at 12:10 P.M., interview with a QMA #4 (Qualified Medication Aid), the person passing medications for Resident #10, at this time indicated, "...she [Resident #10] always does her own treatments [nebulizer]...the nurse comes to get it going and then comes back to finish it...." Interview at this time with LPN #6 (Licensed Practical Nurse)</p>	F000328	<p><b>F328 – Treatment/Care for Special Needs</b></p> <p>It is the practice of this provider to ensure that residents receive proper treatment and care for special services. Respiratory care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Staff #6 was immediately re-educated with return demonstration on policy and procedure for care of resident with respiratory treatments by staff educator. An all nursing staff training related to residents with special care needs will be conducted. This training will include review of the policy and procedures as it relates to adherence of infection control practices and will include hands on demonstration. Resident # 10 is provided supervised nebulizer treatments by licensed nursing staff.</p> <p>Resident # 10 experienced no negative outcomes related to this finding.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be</b></p>	09/11/2014			

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	<p>indicated, "...she [Resident #10] does her own treatments, she is able too...she should have an order but I can't find one...this is the first time I have taken care of her but I know she can do it herself because she can feed herself...."</p> <p>On 8-8-2014 at 9:45 A.M., interview with the MDS (Minimum Data Set [an assessment tool]) Coordinator indicated, "...she [Resident #10] does not self-administer her own medications and the nurse should be in the resident room for the entire nebulizer treatment...."</p> <p>On 8-11-2014 at 10 A.M., review of the physician orders for Resident #10, dated 5-20-2014, indicated, "Levalbuterol HCL [an inhalation medication] 1.25 mg [milligrams]/3 ml [milliliter], inhalation, TID [three times daily] 8 AM, 2 PM, 10 PM...Observe heart rate, respiratory rate during each nebulizer tx [treatment]...."</p> <p>On 8-11-2014 at 10:30 A.M., record review of Nebulizer Treatment policy and procedure, dated and reviewed 09/2012, received from the Nurse Consultant on 8-11-2014 at 10:27 A.M., indicated, "...Procedure Steps:...10. Instruct and remind resident to breathe 'slow and deep' through their mouth for the duration of the therapy...11. Stay with the resident during entire procedure...12. Encourage</p>		<p><b>identified and what corrective action(s) will be taken:</b> All residents requiring respiratory treatments have the potential to be affected. All licensed nursing staff will be re-educated, by the Continuing Education Coordinator/designee, per facilities policy on respiratory treatments by 9/11/14.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> All nurses will be required upon hire and annually to successfully complete skills validation related to respiratory treatments with return demonstration. If it is identified that the staff need further experience and education it will be provided on a one-to-one basis. The DNS/designee will conduct rounds on all shifts to ensure compliance with facility policy and procedure for respiratory care.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b> To ensure ongoing compliance with this corrective action, the DNS/designee will be conducting audits to ensure that respiratory treatments are given per policy and procedure. Audits will be completed daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for six months. If</p>		

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F000371	<p>the resident to occasionally take an 'extra deep' breath to promote deep penetration of the medication into the lungs...13. During procedure perform assessment including pulse, respiration, breath sounds and pulse oximetry...."</p> <p>On 8-11-2014 at 10:35 A.M., interview with the Clinical Education Coordinator indicated, "...we train the nursing staff to remain with the resident during the nebulizer treatment...we have no residents that self-medicate in our facility...."</p> <p>3.1-47(a)(6)</p>		<p>threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow-up</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p>		

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SS=F	<p><b>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b> The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure equipment and dishes were stored under sanitary conditions in the kitchen. This deficient practice affected 1 of 1 kitchens.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure residents were served food under sanitary conditions related to infection control practices. This deficient practice had the potential to affect all residents who eat their meals in 1 of 4 dining rooms at the facility.</p> <p>Findings include:</p> <p>A. 1. On 8/5/14 between 11:10 A.M., and 11:30 A.M., during the initial kitchen tour the following was observed:</p> <ul style="list-style-type: none"> <li>- A metal scoop was observed inside the ice machine on top of the ice.</li> <li>- 11 small gray bowls were observed stored on their side in a gray rubber tub that was sitting on a metal shelving unit</li> </ul>	F000371	<p><b>F371 – Food procure, store/prepare/serve - sanitary</b> It is the practice of this provider to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions.</p> <p><b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></b> Dietary staff will be re-educated, by the Dietary Manager/designee, regarding proper storage of the ice scoop when not in use. Dietary staff will be re-educated, by the Dietary Manager/designee, regarding proper storage of bowls and plates. Staff was immediately re-educated, by the Dietary Manager/designee, regarding proper serving techniques when placing resident plates, bowls and glass ware. The residents did not experience any negative outcomes related to the deficient concern.</p> <p><b><i>How other residents having the potential to be affected by the same deficient practice will be</i></b></p>	09/11/2014			

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	<p>in the dishwashing room of the kitchen. The dishwashing room was observed to have items that needed to be washed stored beside the metal shelving unit.</p> <p>An interview with the Certified Dietary Manager was conducted at this time. The Certified Dietary Manager indicated the ice scoop should not be left in the ice machine and the bowls that were stored upright and on their side were probably from the night before and that they (staff) store in the tub and on the metal shelving unit after they wash them and then take them to the other side ( another room in the kitchen) where they are stored until used.</p> <p>On 8/12/14 at 2:15 P.M., the Nurse Consultant provided the following updated policy titled. "[Corporate Name] Cleaning Ice Machine and Scoop" Review of the policy indicated the following: "...8. Store ice scoop beside or on top of the machine in a clean non-porous container that allows water to drain off ( and not pool around the scoop)...."</p> <p>On 8/12/14 at 2:20 P.M., the Nurse Consultant provided the following updated policy titled. "[Corporate Name] Handling Clean Equipment and Utensils" Review of the policy indicated the</p>		<p><b>identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected.</p> <p>Dietary staff will be in-serviced, by the Dietary Manager/designee, regarding proper storage of the ice scoop when not in use.</p> <p>Dietary staff will be in-serviced, by the Dietary Manager/designee, regarding proper storage of bowls and plates.</p> <p>All staff responsible for serving meals will be in-serviced, by the Dietary Manager/designee, regarding proper serving techniques when placing resident plates, bowls and glass ware.</p> <p>The Dietary Manager/designee will monitor the proper storage of the ice scoop and bowls and plates after each meal.</p> <p>The Dietary Manager/designee will monitor the proper serving techniques when placing resident plates, bowls and glass ware for each meal.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The Dietary Manager/designee will monitor, daily, the proper storage of the ice scoop, bowls and plates.</p> <p>The Dietary Manager/designee will monitor, at each meal, the proper serving techniques when placing resident plates, bowls and glass ware.</p> <p>If concerns are noted, the Dietary</p>				

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	<p>following: "...2. Clean equipment and utensils will be stored in a clean, dry location in a way that protects them from contamination by splashes and dust. Stationary equipment will also be protected from contamination...."</p> <p>B.1. On 8/5/14 at 12:15 P.M. to 12:30 P.M., the following observations were made in the Main Dining Room:</p> <ul style="list-style-type: none"> <li>- Employee # 8 was observed serving food to multiple residents with her thumbs on plates and handling bowls of food with her hand covering the opening of the bowl.</li> <li>- Employee #9 was observed serving food to multiple residents with her thumbs on plates and handling bowls of food with her hand covering the opening of the bowl.</li> </ul> <p>On 8/12/14 at 1:55 P.M., an interview was conducted with the Clinical Education Coordinator. The Clinical Education Coordinator indicated that she teaches staff to set the tray of food down and move the bowl with both hands if possible. Hands should be placed underneath the bowl of jello or fruit or with hands placed around the side of the bowl and not with hands over the top of the bowl.</p>		<p>Manager/Executive Director/Designee will be notified immediately for corrective action. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b> To ensure ongoing compliance with this corrective action, the Dietary Manager/designee will be responsible for completion of the CQI tools titled, "Meal Service Observation" and "Kitchen Sanitation/Environmental Review" daily for 2 weeks, weekly for 2 weeks, bi-weekly for 2 weeks and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p>				

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	<p>On 8/12/14 at 2:20 P.m., the Nurse Consultant provided the following updated policy titled. "[Corporate Name] Handling Clean Equipment and Utensils" Review of the policy indicated the following: "...1. When handling clean and sanitized equipment and utensils, the staff will avoid touching the parts that will come into contact with food. Be especially careful with flatware...."</p> <p>3.1-21(i)(2)</p>			
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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on observation, interview and record review, the facility failed to ensure</p>	F000441	F441 – Infection Control, prevent spread, linens	09/11/2014			

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	<p>catheter tubing did not come into contact with the floor. This deficient practice affected 2 of 2 residents observed with catheters. (Resident #21 and Resident #162)</p> <p>B. Based on observation, interview and record review, the facility failed to ensure one resident's nebulizer inhalation mouthpiece was stored properly in order to keep it clean and sanitary. (Resident #60)</p> <p>Findings include:</p> <p>A. 1. On 8-5-14 at 11:55 A.M., Resident #21 was observed in the Conversation Cafe (Unit 2 Dining Room). A dark blue dignity bag, covering Resident #21's catheter drainage bag, and the catheter tubing was dragging on the floor.</p> <p>On 8-7-14 at 10:30 A.M., Resident #162 was observed in his room. A dark blue dignity bag, covering Resident #162's catheter drainage bag, and the catheter tubing was dragging on the floor. Resident #162 was rocking back and forth in his wheelchair and running over the catheter tubing each time his wheelchair moved.</p> <p>On 8-8-14 at 2:00 P.M., Resident #162 was observed in his room with his dark</p>		<p>It is the practice of this provider to ensure to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident #21 and #162 catheters were immediately assessed to ensure proper placement. Clips were attached to wheelchairs to hold the tubing off the floor. The dignity bags were adjusted to ensure that they fit properly on the wheel chairs and do not drag on the floor. No harm was incurred to resident #21 or #162 related to this deficient practice.</p> <p>Resident #60's nebulizer mouth piece was discarded, replaced and is now properly stored.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents who require catheter bags have been evaluated to ensure safe practice with tubing and dignity bag. No other residents were identified related to this deficient practice.</p> <p>All residents who require nebulizer treatments have had their mouth pieces checked to ensure the mouth pieces are being stored properly.</p> <p><b>What measures will be put into</b></p>	

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	<p>blue dignity and catheter tubing dragging on the floor.</p> <p>During an interview on 8-11-14 at 2:13 P.M., the CEC (Clinical Education Coordinator) indicated it was her expectation and the way she trains staff that catheter bags and tubing be kept up off the floor. The CEC indicated they did not have a facility policy for catheter bags and tubing but indicated the CQI (Continuous Quality Improvement) checklist for catheter assessment is what she uses. Review at this time of the CQI Catheter Assessment Checklist, received from the CEC, indicated "...Catheter tubing is not touching or dragging on the floor...."</p> <p>B.1. On 8-6-14 at 9:39 A.M., Resident #60's room was observed to have a nebulizer machine at her bedside. The inhalation mouthpiece was resting on the bedside table open to air.</p> <p>On 8-11-14 at 11:15 A.M., Resident #60's nebulizer machine was observed with the inhalation mouthpiece open to air and resting on the seat of the residents wheelchair beside her bed.</p> <p>On 8-11-14 at 1:58 P.M., Resident #60's nebulizer machine was observed with the inhalation mouthpiece open to air and</p>		<p><b>place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>Audits will be on-going to ensure compliance with infection control policy and procedure. An in-service, by the Continuing Education Coordinator, will include the review of the policy titled "Infection Control". This in-service will, completed by 9/11/14, and include the proper placement of catheter tubing and dignity bags. Audits on all 3 shifts will be conducted by the nurse management team to monitor compliance.</p> <p>Audits will be on-going to ensure compliance with infection control policy and procedure. An in-service, by the Continuing Education Coordinator, will include the review of the policy titled "Infection Control". This in-service will, completed by 9/11/14, and include the proper care of nebulizer mouth pieces. Audits on all 3 shifts will be conducted by the nurse management team to monitor compliance.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI tool titled, "Infection Control Review" daily for 3 weeks, weekly for 3 weeks,</p>				

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	<p>laying in the middle of her bed.</p> <p>During an interview on 8-11-14 at 2:14 P.M., the CEC indicated nebulizer mouthpieces should be cleaned after every use and stored in a clear plastic bag with a date on it. Review of the "Nebulizer Treatment" policy at this time, received from the CEC, indicated "...17. When therapy completed, the nebulizer medicine cup [part of the inhalation mouthpiece] is rinsed with sterile water, wipe dry with alcohol pad and placed in a clear plastic bag. (Bag should be dated)...."</p> <p>3.1-18(b)(1)</p>		<p>bi-weekly for 3 weeks and monthly for six months. If threshold of 90% is not met, an action plan will be developed. The infection control nurse will track and trend all facility infections. Findings will be submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/11/14</p>		