

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
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NAME OF PROVIDER OR SUPPLIER MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN46058
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 18, 19, 20, 21, and 24, 2011</p> <p>Facility number: 000470 Provider number: 155600 AIM number: 100289210</p> <p>Survey team: Donna M. Smith, RN, TC Tammy Alley, RN Toni Maley, BSW Shelley Reed, RN</p> <p>Census bed type: SNF: 30 SNF/NF: 110 Residential: 5 Total: 145</p> <p>Census payor type: Medicare: 24 Medicaid: 77 Other: 44 Total: 145</p> <p>Sample: 24 Supplemental sample: 1</p> <p>These deficiencies reflect state findings</p>	F0000	<p>Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Mulberry Health & Retirement Community, Inc. that the allegations contained in the survey report are true and accurate portrayal of the provisions of nursing care and other services at this healthcare facility. The facility recognizes its obligation to provide legally and medically required services to its residents in an economic and efficient fashion. The facility hereby maintains that it is in substantial compliance with Federal participating requirements for nursing homes participating in the Medicare and/or Medicaid programs. As a result, this plan of correction constitutes an allegation of compliance of Federal and State regulations.</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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F0253 SS=C	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/31/11 by Suzanne Williams, RN</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observations, record review, and interviews, the facility failed to ensure the common areas were scheduled routinely to maintain a clean and sanitary environment in these common areas. This had the potential to impact 140 of 140 residents who reside in the facility.</p> <p>Findings include:</p> <p>1. On 10/19/11 from 8:45 a.m. to 9:20 a.m., the following was observed:</p> <p>a.) In the open area of the entry to the 200 hallway, the windows next to the exit door were observed with a layer of dust on the window sills with a cobweb present in a corner of the one window.</p> <p>b.) In the Alzheimer's (100) unit, the following was observed:</p> <p>In the sun room at the end of the first hallway, the metal threshold of the exit door was observed with an accumulation of brown to dark brown debris in each corner of it.</p>	F0253	<p>F253 No action can be taken for those residents potentially affected as the incident has already occurred. Those items identified specifically in the survey will be addressed initially. All residents have the potential to be affected. Environmental services manager will establish a schedule for cleaning common area window blinds, corridor ceiling lights, and exit doorway thresholds. Housekeeping personnel will be in-serviced on new cleaning schedule.</p> <p>Environmental Service Manger will utilize a CQI tool once weekly for the first eight weeks to assure consistent and ongoing compliance as well as prompt identification and resolution to noncompliance.</p> <p>A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to effectively identify areas of noncompliance and barriers to achieving compliance on an ongoing basis. If compliance thresholds are not achieved within the first sixty days then the monitoring period will be extended to a level found</p>	11/24/2011			

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	<p>In the dining room the ceiling light in the kitchen area above the end of the counter was observed with an accumulation of brown substance inside the light cover mainly on each end of the light cover.</p> <p>Down the second hallway, 4 of the 5 ceiling lights were observed with brown debris inside the covers. At the end of this hallway in the sun room, an accumulation of dark brown/brown debris in the door's metal threshold was observed at the opening end of this exit door.</p> <p>Three of the three window sills and the window blinds were observed with a layer of light gray dust on them.</p> <p>c.) Upon exiting the Alzheimer's unit, in this hallway the windows at the exit door were observed with a layer of dust on the window sills with a cobweb present in one corner of one of the windows.</p> <p>d.) In the TV area across from the main dining room, one of the two windows was observed with a cobweb in a corner and loose layer of dust on the window blinds.</p> <p>2. On 10/20/11 from 1:30 p.m. to 3:35 p.m. during the environmental tour with the Maintenance Supervisor and the Housekeeping Supervisor, the following was observed:</p> <p>a.) In the 300 hall in the shower room,</p>		appropriate by the CQI committee.		

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	<p>the ceiling vent was observed with a layer of gray dust on the grill cover. The blinds and window sills were observed with a layer of light gray dust on them. In the bathroom area of this shower room, the ceiling vent also was observed with a layer of gray dust on 1 side of the vent.</p> <p>b.) In the TV area across from the main dining room, one of the two windows was observed with a cobweb in a corner and loose layer of dust on the window blinds.</p> <p>c,) In the Beauty Shop, 4 of the 4 window blinds were observed with a layer of light gray dust.</p> <p>d.) In the open area of the entry to the 200 hallway, the windows next to the exit door were observed with a layer of dust on the window sills with a cobweb present in a corner of the one window.</p> <p>e.) In the 200 hall, the following was observed:</p> <p>In the first of the 2 hallways observed, 4 ceiling lights observed contained light brown substances inside the light covers. At this same time during an interview, the Housekeeping Supervisor indicated the light covers were cleaned quarterly.</p> <p>At the end of 1 of the 2 hallways, loose</p>				

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	<p>gray/brown debris with accumulation of dust/hair ball were observed at the exit door.</p> <p>f.) In the 100 unit, the following was observed:</p> <p>Upon entering the unit, two ceiling light covers contained brown debris.</p> <p>In the sun room at the end of the first hallway, the metal threshold of the exit door was observed with an accumulation of brown to dark brown debris in each corner of it.</p> <p>In the dining room the ceiling light in the kitchen area above the end of the counter was observed with an accumulation of brown substance inside the light cover mainly on each end of the light cover.</p> <p>Down the second hallway, 4 of the 5 ceiling lights were observed with brown debris inside the covers. At the end of this hallway in the sun room, an accumulation of dark brown/brown debris in the door's metal threshold was observed at the opening end of this exit door.</p> <p>Three of the three window sills and the window blinds were observed with a layer of light gray dust on them.</p> <p>g.) Upon exiting the 100 unit in the</p>				

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	<p>hallway the windows at the exit door were observed with a layer of dust on the window sills with a cobweb present in one corner of one of the windows.</p> <p>h.) In the 400 hall, the following was observed:</p> <p>Down the first hallway at the exit door, the electric heater grill was observed with a layer of gray dust covering it. At this same time during an interview, the Housekeeping Supervisor indicated the staff had just dusted the vents/grill coverings and must had missed that one.</p> <p>Three of the hallway's ceiling lights observed were observed with brown substance in the covers.</p> <p>3. On 10/21/11 at 3:50 p.m. during an interview, the Administrator indicated there was "no real" written cleaning schedule to follow for cleaning the common areas.</p> <p>3.1-19(f)</p>				

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F0309 SS=E	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, observation, and interview, the facility failed to ensure parameters for Glucagon (hypoglycemia) were followed, an insulin sliding scale was timely clarified, accuchecks and insulin coverage were completed as ordered by the physician, and medications were available for administration regarding a resident receiving an additional anti-seizure medication with the resident continuing to have seizures and a resident receiving a medication to reduce gastric secretions resulting in emesis, for 6 of 21 residents reviewed for medications and treatment in a sample of 24. (Resident's 40, 138, 12, 75, 97, and 86)</p> <p>Findings include:</p> <p>1. Resident #40's record was reviewed on 10/19/11 at 1:38 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus Type II.</p> <p>The physician order, dated 9/30/11, was accuchecks 2 times a day and follow the moderate sliding scale. The moderate scale was to cover the blood sugars. This</p>	F0309	<p>F309 No action can be taken for those residents affected as the incident has already occurred. All residents receiving accuchecks or insulin administration have the potential to be affected. Licensed Nursing staff will be in-serviced on facility policy and procedures for accuchecks, insulin administration, and refusal of coverage. Additionally a facility policy will be developed and nurses in-serviced regarding how to handle the medication orders by a physician that are non-covered medicines by the State of Indiana Medicaid system. This facility cannot control what the State is willing to pay for so the policy will reflect the need to get an immediate hold order on any medications that the State of Indiana refuses to pay for or requires a prior authorization.</p> <p>A CQI audit tool will be utilized to monitor that all medications ordered by the physician or authorized health care provider are administered as ordered. The tool will be utilized four times a week for the first four weeks and two times a week for the next 30 days targeting a random sample of nurses and shifts.</p>	11/24/2011	

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	<p>sliding scale was as follows: 111-150 = 2 units (u); 151-200 = 3 u; 201-250 = 5 u; 251-300 = 9 u; 301-350 =11 u; 351-400 =13 u; 401-500 =15 u; 501-600 = 18 u.</p> <p>The "CAPILLARY BLOOD GLUCOSE MONITORING TOOL" indicated the following:</p> <p>On 10/1 at 4 p.m., BS (blood sugar) was 165 with 2 units (u) of insulin coverage given (BS 151-200 = 3 u);</p> <p>On 10/7 at 5 p.m., BS was 297 with 6 units of insulin coverage given (BS 251-300 = 9 u);</p> <p>On 10/9 at 12 noon, BS was 312 with 11 units of insulin coverage given per the resident's request;</p> <p>On 10/16 at 8 a.m., BS was 67 and at 5 p.m. no information concerning a BS was indicated.</p> <p>The "NURSE'S NOTES" indicated no information concerning the resident's blood sugar results on 10/16/11.</p> <p>On 10/21/11 at 3:50 p.m. during the daily exit conference meeting with the Administrator and the Director of Nursing (DON), information was requested concerning Resident #40's related blood sugar information.</p> <p>On 10/24/11 at 4:45 p.m. at the exit</p>		<p>A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to effectively identify areas of noncompliance and barriers to achieving compliance on an ongoing basis. If compliance thresholds are not achieved within the first sixty days then the monitoring period will be extended to a level found appropriate by the CQI committee.</p>		

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	<p>conference with the Administrator and DON, no further information was provided concerning insulin medications and/or coverage.</p> <p>2. Resident #138's record was reviewed on 10/21/11 at 2:55 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus Type II.</p> <p>The physician order, dated 9/21/11, was Glucagon (hypoglycemia) 1 milligram (mg) injection prn (as needed) for low blood sugar. (No parameters were given concerning the low blood sugar.) The physician order, dated 7/29/11, was accuchecks before meals and at bedtime.</p> <p>The "MEDICATION RECORD," dated 9/01 through 9/30/11, indicated the following:</p> <p>Glucagon 1 mg injection prn was given on 9/21/11 at 1:45 p.m. No information was indicated in the "NURSE'S MEDICATION NOTES" on the back of the medication record.</p> <p>The "NURSE'S NOTES" indicated on 9/21/11 at 1:45 p.m., the resident was noted to be unresponsive while sitting on the toilet in the bathroom. The resident was noted to be diaphoretic with a blood sugar result of 155. The resident was</p>			

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	<p>indicated to be in the past symptomatic with "levels under 160." The resident continued to be unresponsive for 3 minutes and then, vomited large amounts. After she was transferred to her bed, she was given the prn Glucagon. After 2 minutes the resident responded to staff. Her blood sugar at 2:15 p.m. was 208 and at 3:30 p.m. was 283. No further information was indicated concerning any further supplements, ect. had been given.</p> <p>The "CAPILLARY BLOOD GLUCOSE MONITORING TOOL" indicated the following:</p> <p>After the 9/21 1:45 p.m., the blood sugar (BS) at 5:00 p.m. was 284 with the insulin coverage refused per resident and at 9 p.m., the BS was 312 with the insulin coverage refused per resident.</p> <p>Between 9/29 at 9 p.m. to 9/30 at 5 p.m., the BS of 255 and 358 were indicated with no information concerning the date, time, and/or if insulin coverage was given and/or refused with no nurse signature.</p> <p>On 10/21/11 at 3:50 p.m. during the daily exit conference meeting with the Administrator and the Director of Nursing (DON), information was requested concerning Resident #138's related blood sugar information. The DON indicated</p>				

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	<p>parameters should be indicated.</p> <p>On 10/24/11 at 4:45 p.m. at the exit conference with the Administrator and DON, no further information was provided concerning insulin medications and/or coverage.</p> <p>3. Resident #12's record was reviewed on 10/20/11 at 11:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II.</p> <p>The discharge physician's order, dated 10/12/11, was insulin lispro sliding scale subcutaneously as needed with testing for serum glucose (accuchecks). No information was indicated for timing of the accuchecks.</p> <p>The physician order, dated 10/15/11 was to resume previous orders prior to hospital stay.</p> <p>The physician order, dated 10/16/11, was for order clarification and was accuchecks before meals and at hour of sleep and to cover the blood sugars utilizing the lispro moderate sliding scale: 111-150 = 2 units (u); 151-200 = 3 u; 201-250 = "6" u; 251-300 = 9 u; 301-350 =11 u; 351-400 =13 u.</p> <p>The "CAPILLARY BLOOD GLUCOSE MONITORING TOOL" indicated the following:</p>			

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	<p>Accuchecks for the blood sugars (BS) were completed on 10/13 at 8 a.m., 12 noon, and 4 p.m.; on 10/14 at 8 a.m., 12 noon, 4 p.m., and 8 p.m.; on 10/15 at 4 p.m., and 8 p.m.; and on 10/16 at 8 a.m. and 12 noon with no insulin coverage given. The BS's ranged from the lowest of 122 to the highest of 199.</p> <p>On 10/17 at 8 p.m., BS was 229 with 6 units (u) of insulin coverage given (moderate scale indicated BS 201-250 - 5 u);</p> <p>On 10/18 at 8 a.m., BS was 203 with 6 units (u) of insulin coverage given (moderate scale indicated BS 201-250 - 5 u);</p> <p>On 10/19 at 8 a.m., BS was 155 with 2 units (u) of insulin coverage given (BS 151-200 = 3 u);</p> <p>On 10/19 at 12 noon, BS was 143 with 3 u of insulin coverage given (BS 111-150 = 2 u);</p> <p>On 10/19 at 4 p.m., BS was 237 with 6 units (u) of insulin coverage given (moderate scale indicated BS 201-250 - 5 u).</p> <p>The hospital "DISCHARGE SUMMARY," dated 10/11/11 and electronically signed 10/12/11, indicated the discharge medications included, but were not limited to, Insulin lispro mild</p>			

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	<p>sliding scale coverage for blood sugars before meals and at hour of sleep.</p> <p>The hospital admission history and physical, dated 10/15/11, indicated the resident had come to the hospital due to a low hemoglobin where she received blood transfusion and was returned to the facility.</p> <p>On 10/21/11 at 9:45 a.m. during an interview, LPN #4 indicated she had not seen a sliding scale for Resident #12 until the clarification order was written on 10/16/11.</p> <p>On 10/24/11 at 1:35 p.m., information concerning the resident's insulin and insulin coverage was requested from the Director of Nursing.</p> <p>On 10/24/11 at 4:45 p.m. at the exit conference with the Administrator and DON, no further information was provided concerning insulin medications and/or coverage.</p> <p>4. The record for Resident # 75 was reviewed on 10/18/11 at 5:40 p.m.</p> <p>Current diagnoses included, but were not limited to, Diabetes Mellitus.</p> <p>Current physician orders, indicated an order for Accuchecks to be completed</p>				

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	<p>three times daily with sliding scale insulin to be given for an accucheck of 111-150=3 units and 151-200=4 units. Original date of order was 9/10/11.</p> <p>The "Blood Glucose Monitoring Log" for September 2011 indicated there was not accucheck taken on 9/7/11 at 12 p.m. and 9/16/11 at 6 p.m. The log also indicated the resident's accucheck on 9/6/11 at 6 a.m. was 153. No insulin coverage was documented and the resident should have received 4 units. On 9/7/11 at 6 a.m., the resident's accucheck was 148 and received 4 units of insulin but should have received 3 units.</p> <p>Additional information was requested from the Director of Nursing on 10/21/11 at 1:20 p.m., regarding the above accuchecks and sliding scale insulin.</p> <p>On 10/ 24/11 at 10:20 a.m., during interview, the Director of Nursing indicated she had no additional information to provide regarding the above.</p> <p>5. The record for Resident # 86 was reviewed on 10/21/11 at 10 a.m.</p> <p>Current diagnoses included, but were not limited to, Diabetes Mellitus.</p>				

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	<p>Current physician orders indicated an order for sliding scale insulin to be given for an accucheck of 201-250=4 units and 301-350=8 units. Original date of order was 6/29/11.</p> <p>The "Blood Glucose Monitoring Log" for September 2011 indicated the resident's accucheck on 10/22/11 at 4 p.m. was 332 and 4 units of insulin was documented as given, but it should have been 8 units. On 10/13/11 at 8 p.m., the resident's accucheck was 203. No sliding scale insulin was documented as given.</p> <p>On 10/ 24/11 at 10:20 a.m., during interview, the Director of Nursing indicated she had no additional information to provide regarding the above.</p> <p>6. The record for Resident # 97 was reviewed on 10/18/11 at 3:20 p.m.</p> <p>Current diagnoses included, but were not limited to, seizure disorder.</p> <p>A plan of care dated 9/28/11 indicated a problem of seizures with approaches that included, but were not limited to, medicate as ordered.</p> <p>A nursing note dated 9/27/11 at 9:30 a.m., indicated the resident was unresponsive</p>			

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	<p>and had tremors in his extremities. The resident was hospitalized overnight. His seizure medications were adjusted at that time.</p> <p>On 10/14/11 the resident was again sent to the emergency room for seizure activity and his medication were again adjusted.</p> <p>During a medication pass observation with RN # 30 on 10/18/11 at 4:05 p.m., Resident # 97 went unresponsive for 8 minutes then began to have tremors in his extremities, indicating seizure activity. The physician and family were notified.</p> <p>A physician order dated 10/19/11 at 10:45 a.m., indicated an order for Vimpat 50 milligrams (seizure medication) to be given twice daily. This medication was in addition to his Keppra and Dilantin which was also for seizure activity.</p> <p>The October Medication Administration Record (MAR) indicated the Vimpat was not given on 10/19/11, 10/20/11, or 10/21/11 due to it was not available from the pharmacy.</p> <p>On 10/21/11 at 8:30 a.m., information was requested from the Director of Nursing regarding the unavailability of the Vimpat.</p>				

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	<p>On 10/21/11 at 9:30 a.m., the Director of Nursing provided a nursing note dated 10/21/11 at 9 a.m., that indicated she had spoken with LPN # 31 on 10/20 regarding the Vimpat. The note indicated a prior authorization was needed and the physician office had been notified. The physician discontinued the Vimpat on 10/21/11 at 9 a.m. and started Lamictal, another seizure medication.</p> <p>A late entry nursing note dated 10/21/11 at 9:10 a.m., indicated the resident was sitting in his wheelchair and was unresponsive with arms and legs shaking,</p> <p>A nursing note dated 10/21/11 at 6:25 p.m., indicated the resident had seizure activity.</p> <p>7. The record for resident # 75 was reviewed on 10/18/11 at 5:40 p.m.</p> <p>Current physician orders for October 2011 indicated the resident had a gastrostomy tube and had an order for Prevacid 30 milligrams (reduces gastric acid secretions and treats gastroesophageal reflux disease) to be given twice daily.</p> <p>The September 2011 MAR indicated the medication was not given on 9/14/11 in the evening through 9/18/11 due to "no supply. Nine doses of the medication was</p>				

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	<p>not given.</p> <p>A nursing note dated 9/15/11 at 6:30 p.m., indicated the resident vomited a medium amount of emesis. A nursing note dated 9/15/11 at 6:35 p.m., indicated the resident vomited a small amount of emesis. On 9/15/11 at 11 p.m., a nursing note indicated the resident vomited a medium amount of emesis. A nursing note on 9/17/11 at 3:30 p.m., the resident had nausea and emesis. No nausea or emesis was documented after this date.</p> <p>On 10/24/11 at 3 p.m., the Director of nursing provided a 10/17/11 pharmacy non-covered item form that indicated the Prevacid was not covered by any payor source. The form was faxed to the facility on 10/17/11 and was returned with a payment signature on 10/19/11. At that time, during interview, she indicated there was some family conflict and the resident's payor source was questioned.</p> <p>8. A policy titled "Medication Ordering and Receiving From Pharmacy" was provided by LPN #32 on 10/24/11 at 4:45 p.m., and deemed as current. The policy indicated: "...Policy Medications and related products are received from the dispensing pharmacy on a timely basis...." A policy titled "Miscellaneous Special Situations" was provided by LPN # 32 on</p>				

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	<p>10/24/11 at 4:45 p.m., and deemed as current. The policy indicated: "...When a non-covered...medication is ordered...the provider pharmacy attempts to have the order changed to a covered...medication or to have the medication covered under a medical necessity waiver...A. When non-covered medications are ordered, the provider pharmacy faxes a non-covered sheet...to the facility...The licensed nurse consults with the resident's physician to seek a change to a covered item...C. If coverage is not available...the pharmacy bills the resident or responsible party, or the facility, as allowed by state law."</p> <p>The "INSULIN COVERAGE SLIDING SCALE" identifying the mild, moderate, or aggressive scale was provided by the Director of Nursing on 10/19/11 at 3:00 p.m. She also indicated the nurses were to write out which sliding scale the residents were to use to be sure the correct insulin coverage was given.</p> <p>The moderate scale was as follows: 111-150 = 2 units (u); 151-200 = 3 u; 201-250 = 5 u; 251-300 = 9 u; 301-350 =11 u; 351-400 =13 u; 401-500 =15 u; 501-600 = 18 u.</p> <p>3.1-37(a)</p>				

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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observations, record review, and interview, the facility failed to ensure anchored catheter tubing was positioned off of the floor to prevent the possibility of infection for 1 of 2 residents observed with anchored catheters in a sample of 24. (Resident #12)</p> <p>Findings include:</p> <p>1. On 10/18/11 at 12:35 p.m., Resident #12 was observed to receive her lunch tray. The resident was observed in her recliner with the Foley catheter (F/C) bag and tubing hooked on a lower bar of her walker in front of the resident keeping it off of the floor. In preparation for lunch, CNA #3 was observed to adjust the recliner placing the resident's elevated feet on the floor with the F/C tubing now touching the floor. After CNA #3 finished setting up the resident's lunch tray on the bedside table, she left the room with the resident's F/C tubing remaining on the floor. Cloudy, yellow tubing with</p>	F0315	<p>F315 No action can be taken for the alleged non-compliance as the incident already occurred. All residents with catheters have the potential to be affected. On 10/24/11 at 4:45 pm at the exit conference Surveyor stated to facility Administrator and Director of Nursing that resident #12 had told her that she wanted the tubing lower because she believed it drained better. Surveyor understood that resident #12 is always adjusting the tubing. Nursing staff will be in-serviced on proper catheter tubing placement.</p> <p>A CQI audit tool to directly monitor catheter tubing will be utilized twice weekly for the first four weeks and once weekly for the next 30 days targeting a random sampling of residents with catheter tubing at varied times.</p> <p>A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to effectively identify areas of noncompliance and barriers to</p>	11/24/2011			

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	<p>sediment was observed in the F/C tubing.</p> <p>On 10/21/11 at 8:45 a.m., Resident #12's F/C tubing was again observed on the floor with the resident sitting in her recliner with the foot rest down. Cloudy, yellow urine with red tinged sediment was observed in the F/C tubing.</p> <p>On 10/20/11 at 1:25 p.m. during an interview, CNA #3 indicated Foley catheter tubing should be kept off of the floor.</p> <p>Resident #12's record was reviewed on 10/20/11 at 11:20 a.m. The resident's diagnoses included, but were not limited to, septicemia, diabetic mellitus Type II, hypertension, history of small-cell cancer of the bladder, and chronic kidney disease.</p> <p>The "Indiana State Department of Health DIVISION OF LONG TERM CARE NURSE AIDE TRAINING PROGRAM JULY 1998" indicated the following:</p> <p>"TOPIC 25: ELIMINATION</p> <p>...5...An indwelling catheter is left in the bladder continually. The CNAs should: ...d...Keep bag and tubing off floor....."</p> <p>3.1-41(a)(2)</p>		<p>achieving compliance on an ongoing basis. If compliance thresholds are not achieved within the first sixty days then the monitoring period will be extended to a level found appropriate by the CQI committee.</p>		

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F0323 SS=E	<p>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 observations and interview, the facility failed to ensure a safe environment related to 4 of 8 electric baseboard heaters observed in 2 of 2 open/sun room areas observed, and 1 of 3 locked cabinets containing cleaning solutions in 1 of 1 activity kitchen area observed. This had the potential to impact 78 of 140 residents residing on the 200 and 300 hallways. This had the potential to impact 41 of 140 cognitively impaired residents.</p> <p>Findings include:</p> <p>1. On 10/19/11 at 8:45 a.m. in the open area as one entered the 200 hallway, 2 of the 4 electric baseboard heaters, attached to the wall, were observed. The sides of the 2 heaters had the sides of the heaters unaligned resulting in the side panels sticking out away from the outer edges of the heaters. The ends of these side panels had a dull pointed end to them.</p>	F0323	<p>F323</p> <p>The baseboard heaters have never been known to cause any injury and they were in the original working condition as installed 25 years ago. Heaters will be removed.</p> <p>Activity Director will in-service activity staff about the need to keep the cabinet locked above the kitchen sink that contains the dish detergent needed for clean up following facility activities with the residents.</p> <p>Activity Director will monitor the cabinet on a daily basis to ensure it remains locked as required.</p> <p>Date of compliance November 24, 2011</p>	11/24/2011

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	<p>2. On 10/20/11 from 1:30 p.m. to 3:35 p.m. during the environmental tour with the Maintenance Supervisor and the Housekeeping Supervisor, the following was observed:</p> <p>a. In the open hallway exiting the 300 hall, 2 of the 4 electric baseboard heaters attached to the wall were observed. The sides of the 2 heaters had the sides of the heaters unaligned resulting in the side panels sticking out away from the outer edge of the heaters. One of these 2 ends had a sharper pointed end to it.</p> <p>b. In the kitchen of the Activity Room, the unlocked cabinet was observed with a 38 fluid ounce bottle of "Joy" detergent, which indicated to keep out of reach of children and was an eye irritant. At this same time during an interview, the Maintenance Supervisor indicated the cabinet should had been locked.</p> <p>The "Roster/Sample Matrix" was provided by the Administrator on 10/18/11 at 2:30 p.m. The "Roster/Sample Matrix" indicated 78 residents resided on the 200 and 300 halls, and 41 residents, excluding the 100 hall (locked unit), were indicated as cognitively impaired with no physical movement restrictions.</p>				

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F0328 SS=D	<p>3.1-45(a)(1)</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review, observation, and interview, the facility failed to ensure respiratory assessments were completed with nebulizer treatments, the nebulizer medication cup was cleaned after treatment for 2 of 3 residents observed receiving nebulizer treatments (Resident # 54 and # 97) in a sample of 24 and failed to ensure licensed staff initiated oxygen therapy for 1 of 1 observation of oxygen therapy initiation (Resident # 104) in a supplemental sample of 1.</p> <p>Findings include:</p> <p>1. The record for Resident # 54 was reviewed on 10/24/11 at 10 a.m.</p> <p>Current physician orders for October 2011 indicated an order for a Duoneb nebulizer treatment 4 times daily.</p> <p>On 10/19/11 at 9:15 a.m., LPN # 33</p>	F0328	<p>F328 No action can be taken for the alleged non-compliance as the treatments have already occurred. All residents who receive respiratory treatments have the potential to be affected. Licensed nursing staff will be in-serviced on facility policy for nebulizer for aerosol treatments and medication administration specific to documentation requirements for refusal of treatment.</p> <p>A CQI audit tool to directly monitor nebulizer treatments will be utilized twice weekly for the first four weeks and once weekly for the next 30 days targeting a random sampling of residents with nebulizer treatments at varied times.</p> <p>A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to effectively identify areas of noncompliance and barriers to achieving compliance on an ongoing</p>	11/24/2011	

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	<p>initiated a nebulizer treatment for Resident # 54. She left the room as the treatment continued on the resident per a mask. At 9:24 a.m., LPN # 33 entered the room, turned off the nebulizer machine, bagged the mask and medication cup and exited the room. No post treatment vital signs were taken and the medication cup was not rinsed.</p> <p>2. The record for Resident # 97 was reviewed on 10/18/11 at 3:30 p.m.</p> <p>Current physician orders for October 2011 indicated an order for a Duoneb nebulizer treatment every 4 hours.</p> <p>On 10/18/11 at 11:20, LPN # 34 entered the resident's room and removed the nebulizer mask from his face and place the mask and medication cup in a plastic bag at the bedside. No post treatment assessment was completed and the medication cup was not cleaned.</p> <p>The August and September 2011 MAR's indicated the resident did not receive the nebulizer treatment on 8/22/11, 8/26/11, 9/13/11 and 9/22/11 at 4 p.m., because he was not in his room.</p> <p>During interview on 10/24/11 at 10:40 a.m., the Director of Nursing indicated the resident would not come back to this</p>		<p>basis. If compliance thresholds are not achieved within the first sixty days then the monitoring period will be extended to a level found appropriate by the CQI committee.</p>		

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	<p>room for treatment.</p> <p>3. On 10/24/11 at 10:00 a.m., CNA #3 was observed to return with a portable oxygen tank, placed it on Resident #104 's wheelchair, positioned the nasal cannula, and turned the oxygen on with a setting at 2.5 liters.</p> <p>On 10/24/11 at 10:10 a.m. during an interview, LPN #5 indicated the CNA had turned the resident's oxygen to 2.5 liters. She indicated she had completed the resident's oxygen saturation, which was 95%. She also indicated she thought the CNA's could turn and regulated the resident's oxygen.</p> <p>On 10/24/11 at 1:10 p.m. during an interview, the Education Coordinator for the CNA classes indicated the CNA's were not taught to turn on/regulate a resident's oxygen.</p> <p>Resident #104's record was reviewed on 10/24/11 at 2:20 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease.</p> <p>The physician order, dated 10/04/11, was to titrate oxygen to keep oxygen saturations between 90 to 94%.</p> <p>4. A policy titled "Nebulizer for Aerosol</p>			

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	<p>Treatments Hand-Held or Face Mask" was provided by the Director of Nursing on 10/24/11 at 4:20 p.m., and deemed as current. The policy indicated: "...14. Check residents pulse at end of treatment...17. Wash medication residue from the Nebulizer cup and mouthpiece with mild soapy water or face mask. Rinse and dry well...."</p> <p>5. A policy titled "Medication Administration" was provided by the Director of Nursing on 10/24/11 at 10:30 a.m., and deemed as current. The policy indicated: "...18. If a resident refused to take a medication, inform resident of possible consequences of refusal...indicate on administration record...in nurse's notes...."</p> <p>3.1-47(a)(6)</p>				

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, observation, and interview, the facility failed to ensure medications were available for administration for 3 of 21 resident's reviewed for available medications in a sample of 24. (Resident # 97, # 75, and # 138)</p> <p>Findings include:</p> <p>1. The record for Resident # 97 was reviewed on 10/18/11 at 3:20 p.m.</p> <p>Current diagnoses included, but were not limited to, seizure disorder.</p> <p>A plan of care dated 9/28/11 indicated a problem of seizures with approaches that</p>	F0425	<p>F425 In all cases referenced the facility properly ordered the medications as required. Facility cannot control what the State of Indiana or other entities will or will not pay for.No action can be taken as the incidents have already occurred. All residents receiving medications have the potential to be affected. A facility policy will be developed that indicates all residents who have a medication ordered by a physician that is not covered or requires prior authorization by the State of Indiana Licensed nursing staff will obtain a hold order from the physician until issue can be resolved. Licensed nursing staff will be in-serviced on the new facility policy.</p> <p>A CQI audit tool will be utilized to monitor that all medications</p>	11/24/2011	

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	<p>included, but were not limited to, medicate as ordered.</p> <p>A musing note dated 9/27/11 at 9:30 a.m., indicated the resident was unresponsive and had tremors in his extremities. The resident was hospitalized overnight. His seizure medications were adjusted at that time.</p> <p>On 10/14/11 the resident was again sent to the emergency room for seizure activity and his medication were again adjusted.</p> <p>During a medication pass observation with RN # 30 on 10/18/11 at 4:05 p.m., Resident # 97 went unresponsive for 8 minutes then began to have tremors in his extremities, indicating seizure activity. The physician and family were notified.</p> <p>A physician order dated 10/19/11 at 10:45 a.m., indicated an order for Vimpat 50 milligrams (seizure medication) to be given twice daily. This medication was in addition to his Keppra and Dilantin which was also for seizure activity.</p> <p>The October Medication Administration Record (MAR) indicated the Vimpat was not given on 10/19/11, 10/20/11, or 10/21/11 due to it was not available from the pharmacy.</p>		<p>ordered by the physician or authorized health care provider are administered as ordered. The tool will be utilized four times a week for the first four weeks and two times a week for the next 30 days targeting a random sample of nurses and shifts.</p> <p>A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to effectively identify areas of noncompliance and barriers to achieving compliance on an ongoing basis. If compliance thresholds are not achieved within the first sixty days then the monitoring period will be extended to a level found appropriate by the CQI committee.</p>	

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	<p>On 10/21/11 at 8:30 a.m., information was requested from the Director of Nursing regarding the unavailability of the Vimpat.</p> <p>On 10/21/11 at 9:30 a.m., the Director of Nursing provided a nursing note dated 10/21/11 at 9 a.m., that indicated she had spoken with LPN # 31 on 10/20 regarding the Vimpat. The note indicated a prior authorization was needed and the physician office had been notified. The physician discontinued the Vimpat on 10/21/11 at 9 a.m. and started Lamictal, another seizure medication.</p> <p>A late entry nursing note dated 10/21/11 at 9:10 a.m., indicated the resident was sitting in his wheelchair and was unresponsive with arms and legs shaking,</p> <p>A nursing note dated 10/21/11 at 6:25 p.m., indicated the resident had seizure activity.</p> <p>2. The record for resident # 75 was reviewed on 10/18/11 at 5:40 p.m.</p> <p>Current physician orders for October 2011 indicated the resident had a gastrostomy tube and had an order for Prevacid 30 milligrams (reduces gastric acid secretions and treats gastroesophageal reflux disease)to be given twice daily and</p>				

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	<p>Pulmicort 1 vial per nebulizer twice daily. (respiratory medication)</p> <p>The September 2011 MAR indicated the Prevacid was not given on 9/14/11 in the evening through 9/18/11 due to "no supply. Nine doses of the medication was not given. The Pulmicort was not given on 9/24 and 9/25/11, missing three doses.</p> <p>On 10/24/11 at 3 p.m., the Director of nursing provided a 10/17/11 pharmacy non-covered item form that indicated the Prevacid was not covered by any payor source. The form was faxed to the facility on 10/17/11 and was returned with a payment signature on 10/19/11. At that time, during interview, she indicated there was some family conflict and the resident's payor source was questioned.</p> <p>3. Resident #138's record was reviewed on 10/21/11 at 2:55 p.m. The resident's diagnoses included, but were not limited to, osteoporosis and diabetic mellitus Type II.</p> <p>The "MEDICATION RECORD," dated 10/01 through 10/31/11, indicated the following:</p> <p>Ketoprofen 150 mg/ml apply 1 ml topically to the right shoulder 4 times daily, hospice provides;</p>				

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	<p>Ketoprofen 150 mg/ml apply 1 ml topically to the left upper arm 4 times daily, hospice provides.</p> <p>Both of these ordered medications were indicated as unavailable/not given from 10/09 at 6:00 a.m. through 10/12 at 6:00 a.m. The "NURSE'S MEDICATION NOTES" indicated on 10/09/11 at 12 a.m. and 6 a.m., Keptoprofen was not available and on 10/12/11 at 12 a.m. and 6 a.m., there was no supply.</p> <p>On 10/24/11 at 1:35 p.m., information concerning the unavailability of the above medications was requested from the Director of Nursing.</p> <p>On 10/24/11 at 4:45 p.m. at the exit conference with the Administrator and DON, no further information was provided concerning medications availability.</p> <p>4. A policy titled "Medication Ordering and Receiving From Pharmacy" was provided by LPN #32 on 10/24/11 at 4:45 p.m., and deemed as current. The policy indicated: "...Policy Medications and related products are received from the dispensing pharmacy on a timely basis...." A policy titled "Miscellaneous Special Situations" was provided by LPN # 32 on 10/24/11 at 4:45 p.m., and deemed as current. The policy indicated: "...When a</p>				

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	<p>non-covered...medication is ordered...the provider pharmacy attempts to have the order changed to a covered...medication or to have the medication covered under a medical necessity waiver...A. When non-covered medications are ordered, the provider pharmacy faxes a non-covered sheet...to the facility...The licensed nurse consults with the resident's physician to seek a change to a covered item...C. If coverage is not available...the pharmacy bills the resident or responsible party, or the facility, as allowed by state law."</p> <p>3.1-25(a)</p>				

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, interviews, and record review, the facility failed to ensure effective infection control practices related to linen, equipment, and handwashing were implemented, which</p>	F0441	F441 This facility does maintain a very detailed infection control program and was able to show the surveyor that facility has had less the 2% noscomial infection rate annually.No action can be	11/24/2011

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	<p>included 2 of 2 linen closets containing employees outerwear (200 and 300 halls), positioning of a resident's wound vacuum tubing for 1 of 1 resident observed (Resident #12) and storage of a measuring cup in brown sugar for 2 of 3 dining room cabinets observed (300 and 400 halls), handwashing technique for 1 of 5 nursing staff observed (LPN #2) during a treatment for 1 of 1 resident observed (Resident #140) and personal care for 1 of 3 residents (Resident #17) observed, and correct knowledge to disinfect shower chair/beds for 1 of 2 CNAs (CNA #7) interviewed. This had the potential to impact 109 of 140 residents residing in the facility.</p> <p>Findings include:</p> <p>1. On 10/18/11 from 11:35 a.m. to 11:45 a.m., Resident #17's personal care was observed. After the resident had voided on the toilet, LPN #2 with gloved hands completed his peri-care, removed her gloves, handwashed for less than 5 seconds, donned another pair of gloves. After she assisted the resident to stand, she completed the resident's care, removed her gloves, redressed the resident and returned him to his wheelchair attaching his personal body alarm. After donning another pair of gloves, she bagged the trash, removed one glove and</p>		<p>taken as incidents already occurred. Licensed nursing staff will be in-serviced on proper hand washing policy and procedures. Nursing staff will be in-serviced on proper placement of all drainage tubes. Nursing staff will be in-serviced not to leave the dispensing cup for the brown sugar in the container, and to not leave personal items in areas that store resident food or linen. A CQI audit tool will be utilized to directly monitor hand washing, wound vac tubing placement and proper shower chair disinfection after use twice weekly for the first four weeks and once weekly for the next 30 days targeting a random sampling of staff across all shifts. A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to effectively identify areas of noncompliance and barriers to achieving compliance on an ongoing</p>				

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	<p>carried the bag out with the remaining gloved hand disposing of it in the soiled utility room. After removing the remaining glove, she handwashed for 12 seconds.</p> <p>2. On 10/18/11 from 2:30 p.m. to 2:40 p.m., Resident #140's treatment to his open areas on his coccyx was observed. LPN #2 was observed to handwash for less than 10 seconds. With gloved hands she assisted the resident to turn onto his left side, poured Multidux powder onto her gloved hand, and placed the powder on the 2 open areas. After the resident was turned back to his back and retaped his brief, she removed her gloves and handwashed for less than 10 seconds. At this same time during an interview, LPN #2 indicated one should handwash for 10 seconds.</p> <p>3. On 10/19/11 at 8:20 a.m., Resident #12 was observed up on the bedside commode. Her wound vacuum tubing was observed touching the floor with red tinged drainage noted in the tubing.</p> <p>On 10/20/11 at 12:50 p.m. during an interview, LPN #4 indicated Resident #12's wound vacuum tubing should be wrapped around her walker to keep it off of the floor due to the potential for infections.</p>			

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	<p>4. The environmental tour was completed with the Maintenance Supervisor and the Housekeeping Supervisor on 10/20/11 from 1:30 p.m. to 3:35 p.m.</p> <p>a.) In the 400 hall, the following was observed:</p> <p>In the dining room in the cabinet, a medicine cup was observed stored inside the brown sugar container.</p> <p>b.) In the 200 hall, the linen closet was observed full of folded linen with employee's personal coats hanging in this same closet.</p> <p>b.) In the 300 hall, the following was observed:</p> <p>In the dining room area in one of the cabinets, a medicine cup was observed stored in the brown sugar container in the cabinet. Also, a personal drink cup with a straw in it and an uncovered baked cupcake were observed in the cabinet. At this same time during an interview, CNA #1 indicated this cabinet and the contents were for the residents' use.</p> <p>In the linen closet, employee's personal coats were observed hung on the wall.</p>			

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	<p>The linen closet had clean linen stacked on all of the shelves of this closet.</p> <p>While checking the 300 hall shower room, CNA #6 was observed to bring a shower bed into the shower and leave the shower room. The shower bed was observed with brown and gray particles scattered on the padded shower bed with particles floating in water inside the center open area of this cushion. During this same time during an interview, CNA #6 indicated she would return to clean the shower bed when we had finished touring in the shower room.</p> <p>When the shower room was checked with the Administrator present, the shower bed was dry with a few brown/gray flakes in the middle hole of the cushion. Upon lifting the cushion up, the upper netting was brown in color.</p> <p>5. On 10/24/11 at 9:45 a.m. during an interview, CNA #7 indicated she was giving the showers today. She also indicated she would disinfect the shower chairs/beds by spraying them with the disinfectant provided in the shower room, leave it on for 30 seconds to 1 minute, and then rinse the shower bed/chair and dry it.</p> <p>On 10/24/11 at 3:55 p.m. during an interview, the Housekeeping Supervisor indicated she mixed the disinfectant</p>				

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	<p>solution for the shower chairs/beds every week. She indicated the 1:10 solution was mixed with "Germicidal Bleach Disinfectant." At this same time the information contained with the disinfectant bleach indicated after wash, wipe or rinse items with detergent and water, apply this sanitizing solution, let stand for 2 minutes, and allow it to air dry.</p> <p>7. The "HAND WASHING" policy was provided by the Director of Nursing on 10/24/11 at 10:20 a.m. This current policy indicated the following:</p> <p>"PURPOSE:</p> <ol style="list-style-type: none"> 1. To prevent the spread of infection or disease from resident to resident, staff to resident, and resident to staff. 2. Proper hand washing technique preserves the health and safety of residents and staff. <p>POLICY:</p> <p>Hand washing will be done before and after direct resident care, before and after removal of gloves, and on completion of each task/job.</p> <p>...HAND WASHING PROCEDURE</p>						

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	<p>STEPS:</p> <p>...4. Lather all areas of hands and wrists, rubbing vigorously for at least 15 seconds....."</p> <p>3.1-18(l)</p>				