

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/17/2013
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT LEBANON	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: 5/13, 5/14, 5/15, 5/16, and 5/17, 2013.</p> <p>Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470</p> <p>Survey Team: Lora Brettnacher, RN, TC Heather Lay, RN Karen Hartman, RN Jeanna King, RN Yolonda Love, RN</p> <p>Census Bed Type: SNF/NF: 35 Total: 35</p> <p>Census Payor Type: Medicare: 4 Medicaid: 24 Other: 7 Total: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 05/23/2013 by Brenda Nunan, RN.</p>	F000000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 6/16/2013.</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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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	It is policy of this facility that	06/16/2013			

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	<p>interview, the facility failed to report an allegation of verbal abuse immediately to the facility Administrator. The deficient practice affected 2 of 5 residents reviewed for alleged abuse violations [Residents #37 and #20].</p> <p>Findings include:</p> <p>1. On 5/14/13 at 1:53 P.M., in an interview, Resident #39's wife indicated she reported an allegation of verbal abuse to Licensed Practical Nurse [LPN] #23 over a month ago that involved an unknown male agency staff aide who spoke rudely to Resident #37 while he provided care.</p> <p>On 5/16/13 at 11:30 A.M., in an interview, the Administrator indicated she was unaware of the allegation of verbal abuse and LPN #23 did not report the allegation.</p> <p>On 5/17/13 at 2:05 P.M., in an interview, the Administrator indicated that LPN #23 was an agency nurse and should have been trained on abuse prior to working.</p>		<p>Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. It is policy of this facility that Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Facility staff were re-educated by Nursing Administration on 5-29-13 on the facility's policy and procedure regarding reporting of abuse, neglect, mistreatment, and misappropriation of property. Agency personnel are educated on the facility policy and procedure regarding abuse, neglect and reporting prior to their employment in the facility. The allegation of verbal abuse was investigated and reported to the ISDH when it was brought to the Administrator's attention by the surveyor. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Residents and families were interviewed by the facility</p>		

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			Guardian Angels, which consists of department heads, to determine if there were any concerns regarding abuse. No concerns were identified; however if a concern is reported it will be placed on the Grievance Concern form and reviewed at the morning QA meeting which is held Monday through Friday. If an allegation of abuse is identified the Administrator will be immediately notified. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Facility staff, which included the Administrator and DON, were re-educated by the Nurse Consultant on 5-29-13 regarding the facility policy and procedure on abuse. Agency staff are educated on the facility policy and procedure regarding abuse prior to providing resident care. Residents and their families are educated on admission as to whom and how to report allegations, incidents, and/or complaints without fear of retaliation. Residents and families are also educated on the process of receiving feedback/resolution regarding concerns that have been expressed. This education occurs at admission, during resident council meetings, and also during the care plan	

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			<p>conference. The facility has a designated employee/supervisor on each shift/tour of duty responsible for the initial reporting and investigation of allegations of mistreatment, neglect, abuse. This designated employee will communicate all investigation information to the administrator, who will determine further action. Any staff found non-compliant in reporting any allegation of abuse will be subject to disciplinary action which includes termination. Any agency staff found to be non-compliant will not be permitted to practice in the facility and the agency will be notified of the non-compliance. Orientation of any new facility staff will also include the facility policy and procedure on abuse. Facility staff are also educated on an annual basis via computerized Silverchair learning process. 4. Describe 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. Monitoring of this practice will occur at least 5 times per week by the facility Guardian Angels, which consists of department heads. Guardian Angels are assigned at sufficient ration, to residents and family members, to ensure resident needs are met. Any allegation that is found and has not been reported will be brought to the Administrator immediately.</p>		

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	<p>2. Resident #20's Record was reviewed on 5/14/2013 at 2:30 P.M. Resident # 20 had a diagnosis which included, but was not limited to, depression. A 14 day Minimum Data Assessment Tool (MDS) dated 4/23/13, indicated Resident #20 was alert, oriented, incontinent, and required total assistance of one person for bed mobility, transfers, and toileting.</p> <p>During an interview on 5/14/2013 at 9:49 A.M., Resident #20 stated "hollered at her." during a shower and stated she, "hated to see her come." She indicated, staff got upset with her and acted mad when she asked to go to the bathroom too many times at night. Resident #20 indicated staff slammed doors and were "mean." Resident #20 stated, "it doesn't bother me to sit in wet when they are busy. They [Certified Nursing Assistants (CNAs) #102 and #103 named] tell me I'm not the only</p>		Results of the daily Guardian Angel rounds are discussed at least 5 times per week at morning QA meetings, which all department heads attend. The Guardian Angel program and results of resident and family interviews are also reviewed by the QA & A Committee at the regularly scheduled monthly meeting.		

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	<p>patient. I am no angel. I tell them what I think, but I expect to be treated with courtesy." Resident # 20 indicated she reported the incidents to the Administrator.</p> <p>During an interview on 5/15/2013 at 3:35 P.M., the Administrator indicated she considered abuse to be when a resident believed they had been intimidated, hit, hurt, threatened, harassed, or neglected. She indicated, if she was notified of an allegation of abuse, she would review the allegation to see if it met the criteria of abuse. The Administrator stated, "If we feel like it is abuse, we report it. We do not report all allegations until we determine it is abuse." At this time, the Administrator was asked to provide documentation of any incidents regarding Resident #20.</p> <p>A document titled, "Investigation", indicated on 4/15/2013 at 1:30 P.M., LPN (Licensed Practical Nurse) #100 reported to the Administrator an allegation that a CNA said "mean things" to Resident #20 about going to the bathroom too much during the evening of 4/14/2013. The Administrator indicated the allegation was not reported to the State Department of Health.</p>				

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	<p>A policy titled "Resident Mistreatment, Neglect, Abuse &amp; Misappropriation of Property," provided by the Administrator, on 5/14/13 at 3:10 P.M., indicated, "... Verbal abuse: Defined as the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to resident... including but not limited to, saying things to frighten a resident... Neglect: Failure to provide goods and services necessary to avoid... mental anguish... Neglect occurs when a facility fails to provide necessary care for residents, such as situations in which residents are being left to lie in urine or feces... All reported incidents of alleged violations involving mistreatment, neglect, or abuse... are reported per state and federal law.... Training: Employees, whether direct care, contract staff, ancillary departments... will receive instruction/training on neglect, abuse, misappropriation of resident belongings, and the reporting requirements during orientation and periodically during ongoing inservice education...."</p> <p>3.1-28(a) 3.1-28(c)</p>						

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <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 record review and interview, the facility failed to implement its policies and procedures for ensuring training in regards to abuse and failed to implement its policy for reporting an allegation of abuse to the administrator and/or state agencies for 2 of 5 residents reviewed for allegations of abuse [Residents #37 and #20].</p> <p>Findings include:</p> <p>1. On 5/14/13 at 1:53 P.M., in an interview, Resident #39's wife indicated she reported an allegation of verbal abuse to Licensed Practical Nurse [LPN] #23 over a month ago that involved an unknown male agency staff aide who spoke rudely to Resident #37 while he provided care.</p> <p>On 5/16/13 at 11:30 A.M., in an interview, the Administrator indicated she was unaware of the allegation of verbal abuse and LPN #23 did not report the allegation.</p>	F000226	<p>It is policy of this facility that Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. It is policy of this facility that Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The concerns involving Residents #39 and #20 were immediately investigated and reported to the ISDH after being brought to the Administrator's attention by the surveyor. The facility's follow-up investigations noted that neither resident exhibited any signs or symptoms of distress, nor were any additional concerns from these residents discovered during the investigation/interview process. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and</p>	06/16/2013	

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	On 5/17/13 at 2:05 P.M., in an interview, the Administrator indicated that LPN #23 was an agency nurse and should have been trained on abuse prior to working.		state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Residents and families were interviewed by the facility Guardian Angels, which consists of department heads, to determine if there were any concerns regarding abuse. No concerns were identified 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Facility staff, which included the Administrator and DON, were re-educated by the Nurse Consultant on 5-29-13 regarding the facility policy and procedure on abuse. Agency staff are educated on the facility policy and procedure regarding abuse prior to providing resident care. Residents and their families are educated as to whom and how to report allegations, incidents, and/or complaints without fear of retaliation. Residents and families are also educated on the process of receiving feedback/resolution regarding concerns that have been expressed. This education occurs at admission, during resident council meetings, and also during the care plan conference. The facility has a designated employee/supervisor on each shift/tour of duty		

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			<p>responsible for the initial reporting and investigation of allegations of mistreatment, neglect, abuse. This designated employee will communicate all investigation information to the administrator, who will determine further action. Any staff found non-compliant in reporting any allegation of abuse will be subject to disciplinary action which includes termination. Any agency staff found to be non-compliant will not be permitted to practice in the facility and the agency will be notified of the non-compliance. Orientation of any new facility staff will also include the facility policy and procedure on abuse.</p> <p>4. Describe 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. Monitoring of this practice will occur at least 5 times per week by the facility Guardian Angels, which consists of department heads. Guardian Angels are assigned at sufficient ration, to residents and family members, to ensure resident needs are met. Any allegation that is found and has not been reported will be brought to the Administrator immediately. Results of the daily Guardian Angel rounds are discussed at least 5 times per week at morning QA meetings, which all department heads attend. The Guardian Angel program and</p>	

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	<p>2. Resident #20's Record was reviewed on 5/14/2013 at 2:30 P.M. Resident #20 had a diagnosis which included, but was not limited to, depression. A 14 day Minimum Data Assessment Tool (MDS) dated 4/23/13, indicated Resident #20 was alert, oriented, incontinent, and required total assistance of one person for bed mobility, transfers, and toileting.</p> <p>During an interview on 5/14/2013 at 9:49 A.M., Resident #20 stated, "hollered at her." during a shower and stated she, "hated to see her come." She indicated, staff got upset with her and acted mad when she asked to go to the bathroom too many times at night. Resident #20 indicated staff slammed doors and were "mean." Resident #20 stated, "it doesn't bother me to sit in wet when they are busy. They [Certified Nursing Assistants (CNAs) #102 and #103 named] tell me I'm not the only patient. I am no angel. I tell them what I think, but I expect to be treated with courtesy." Resident # 20 indicated she reported the incidents to the Administrator.</p>		<p>results of resident and family interviews are also reviewed by the QA &amp;A Committee at the regularly scheduled monthly meeting.</p>				

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	<p>During an interview on 5/15/2013 at 3:35 P.M., the Administrator indicated she considered abuse to be when a resident felt they had been intimidated, hit, hurt, threatened, harassed, or neglected. She indicated, if she was notified of an allegation of abuse, she would review the allegation to see if it met the criteria of abuse. The Administrator stated, "If we feel like it is abuse, we report it. We do not report all allegations until we determine it is abuse." At this time, the Administrator was asked to provide documentation of any incidents regarding Resident #20.</p> <p>A document titled, "Investigation", indicated on 4/15/2013 at 1:30 P.M., LPN (Licensed Practical Nurse) #100 reported to the Administrator an allegation that a CNA said "mean things" to Resident #20 about going to the bathroom too much during the evening of 4/14/2013. The Administrator indicated the allegation was not reported to the State Department of Health.</p> <p>During an interview on 5/15/2013 at 3:35 P.M., the Administrator indicated she considered abuse to be if a resident believed they had been</p>						

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	<p>intimidated, hit, hurt, threatened, harassed, or neglected. She indicated, once notified of an allegation, she would investigate it. If it met the criteria of abuse, she would report it to the State. The Administrator stated, "If we feel like it is abuse, we report it. We do not report all allegations until we determine it is abuse." At this time, the Administrator was asked to provide documentation of any incidents regarding Resident #20.</p> <p>A document titled, "Investigation", indicated on 4/15/2013 at 1:30 P.M., LPN (Licensed Practical Nurse) #100 reported to the Administrator Resident #20 stated a CNA was saying mean things to her about her going to the bathroom too much the evening of 4/14/2013. At this time, the Administrator indicated this allegation was not reported to the State Department of Health.</p> <p>On 5/14/2013 at 3:10 P.M., the Administrator provided the facility's abuse policy and procedures, dated 9/10. The policies and procedures indicated, "...Verbal Abuse: Defined as use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents.... Training: Employees,</p>			

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	<p>whether direct care, contract staff, ancillary departments, volunteers, or consultants, receive instruction/training on neglect, abuse, misappropriation of resident belongings, and the reporting requirements during orientation.... All reported incidents of alleged violations involving mistreatment, neglect, or abuse... are reported per state and federal law..."</p> <p>3.1--28(a)</p>			

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to respect a resident's choice regarding use of an electronic cigarette. This deficient practice affected 1 of 1 resident reviewed for use of an electronic cigarette in a sample of 8 residents reviewed for choices [Resident #39].</p> <p>Findings include:</p> <p>On 5/14/13 at 2:00 P.M., in an interview, Resident #39's wife indicated the facility did not allow her husband [Resident #39] to use his electronic cigarette [smoke free/tobacco free device] in his room with her supervision. Resident #39's wife indicated she had been instructed to stop bringing the device to her husband as she had done when Resident #39 was first admitted in March, 2012. She indicated the facility did not have a policy regarding electronic cigarette use upon her husbands admission and was not</p>	F000242	<p>It is the policy of this facility to allow residents to make choices about aspects of his or her life in the facility that are significant to them. 1. Describe what the facility did to correct the deficient practice cited in the deficiency. The facility will furnish Resident #39's wife with a copy of the current Smoking Policy, along with a letter of explanation by 6-14-13. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents residing in the facility, who were admitted prior to the June 2012 Smoking Policy revision regarding use of electronic cigarettes, have the potential to be affected. These residents and/or their representative or interested family member will be furnished with a copy of the current Smoking Policy, along with a letter of explanation by 6-14-12. 3.</p>	06/16/2013			

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	<p>aware of the policy on admission. Resident #39's wife indicated the electronic cigarette helped to calm her husband. She indicated the facility allowed use of the electronic cigarette outside in the designated smoking area where regular tobacco cigarettes were smoked.</p> <p>On 5/17/13 at 11:15 A.M., in an interview, the Assistant Administrator indicated an electronic cigarette was considered a smoking or tobacco device at the facility and residents were not allowed to use in their rooms regardless of supervision. At that time, she provided the "Smoking Policy," dated 10/10/12. The policy indicated, "...Smoking/Tobacco use is prohibited inside [the facility] and within 8 feet of any entrance...Residents will not be permitted to retain cigarettes, cigars, pipes, tobacco, lighters, matches, or electronic cigarettes...Residents may not retain cigarettes, tobacco, lighters, or matches in room at any time...Family and friends of residents are required to leave any smoking equipment with a nurse...."</p> <p>The facility did not have documentation of an electronic cigarette policy prior to Resident #39's admission in March, 2012.</p>		<p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Facility will continue to furnish a copy of the Smoking Policy to all residents upon admission. If at any time the existing policy is revised, residents and/or their representative or interested family member will be notified by the facility of the changes. 4. Describe 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. Any family/resident concerns or grievances regarding the Smoking Policy will be addressed with a thorough investigation and follow-up. Any ongoing concerns will be reviewed during the monthly QA &amp; A Committee meeting. Recommendations will be discussed and acted upon. Requested addendum 6-26-2013 Immediately after survey, staff took allowed resident to use his e-cigarette whenever he requested; however, after a few days staff noted that resident was seldom asking staff to use his e-cigarette. Staff discussed a possible schedule with him to smoke his e-cigarette either before or after the other residents were smoking. He agreed and</p>		

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	3.1-3(u)(3)		staff initiated this schedule. After some time, he asked if he could be taken out to smoke at the same time the other residents were taken to smoke, because he liked to socialize with them. Staff has adhered to this request and are finding that the resident is enjoying this time with the other residents. Staff have also noticed a positive change in him-he is overtly more friendly to others, more relaxed, and socializes freely during smoking and non smoking times. The social worker visits with him frequently and has told him to notify her if he wishes to change his e-cigarette smoking schedule. At this time he has indicated that he is satisfied with the current plan. The social worker's visits and the resident's response are noted in the medical record, and his care plan has been updated to show his current schedule and status in smoking his e-cigarette. correction date 6-16-2013		

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F000244 SS=D	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to ensure resolution of grievances related to the cleanliness and grooming of a resident who required extensive assistance with Activities of Daily Living were resolved. This deficient practice affected 1 of 1 resident reviewed for grievances [Resident #39].</p> <p>Findings include:</p> <p>On 5/14/13 at 1:51 P.M., in an interview, Resident #39's wife indicated she was upset about her husband [Resident #39] not receiving his scheduled showers as evidenced by his unpleasant odor and unshaven appearance at times. She indicated she had spoken to the Administrator on several occasions regarding Resident #39's cleanliness and grooming.</p> <p>On 5/16/13 at 1:03 P.M., Resident #39's record was reviewed.</p>	F000244	<p>It is the policy of this facility to act upon the grievances and recommendations of residents and families concerning resident care and life in the facility. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #39 is receiving regularly scheduled showers which are being monitored by the DON. Any concern form that was completed by Resident #39's wife has been resolved with follow-up by the appropriate department head. There have been no further concerns documented by Resident 39's wife. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The Guardian Angel rounds have revealed no resident concerns that have not been addressed. Residents and families are educated on the Grievance/Concern form process on admission, and again during</p>	06/16/2013			

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	<p>Diagnoses included, but were not limited to, cognitive decline, hypotension, bi-polar disease, hepatitis, insomnia, anxiety, and depression.</p> <p>An "Activities of Daily Living [ADL] Care Plan," dated 4/4/12 indicated, "...I require extensive staff assistance with completing my daily care/needs... I will receive staff assistance daily to complete my adl tasks to be groomed and dressed daily through next review... I am to receive assistance with showers twice per week, I am to receive bed baths daily between shower days...."</p> <p>On 5/18/13 at 12:00 P.M., Resident #39's "Shower Day Skin Audit" sheets were received from the Director of Nursing [DoN]. At that time, she indicated a CNA [Certified Nursing Aide] completed the sheet when the resident received or was offered their shower.</p> <p>The record indicated that showers were not given as scheduled to Resident #39. The record indicated Resident #39 did not receive 2 of 8 scheduled showers in February 2013 and did not receive 6 of 8 scheduled showers in March 2013 and did not receive 4 of 10 scheduled showers in</p>		<p>the care plan conference to assure all concerns are addressed in the appropriate time frame with follow-up. Any staff member may assist a resident and/or family member with completing a Resident/Family Concern form. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The facility staff were re-educated on the Grievance policy and procedure on 5-29-13 by Nursing Administration. The concern forms are located at each nurses' station for Resident/Family convenience. Once the form has been completed, it will be given to the Administrator or designee. If the concern form is given to a designee, the Administrator is to be notified immediately of the concern. The appropriate staff member will complete a thorough investigation and follow-up will be documented on the concern form. The completed form with the follow-up and resolution documented, will be given to the Administrator for final approval 4. Describe 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. All Grievance/Concern forms are reviewed and</p>		

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	<p>April 2013.</p> <p>On 5/17/13 at 11:15 A.M., the Assistant Administrator provided the "Grievances" policy and procedure, dated 1/2004. The grievance policy and procedure indicated, "...All complaints/concerns will be thoroughly investigated... Resolution will be relayed to residents and/or families within 48 hours...." At that time, in an interview, the Administrator indicated the administrative staff, including but not limited to, herself, the Assistant Administrator, and the Director of Nursing were all new to the facility. Therefore, she was not aware of all past grievances of what had been done to correct the problems other than what she had read. She was unable to provide additional documentation related to Resident #39's grievances.</p> <p>On 5/18/13 at 2:00 P.M., the Administrator provided the "Resident/Family Concern Forms" for Resident #39.</p> <p>A "Resident/Family Concern Form," dated 4/30/13, indicated, "...[Resident #39's wife] noticed dried trails of bowel movement on [Resident #39's] bottom [buttocks] and down legs...</p>		discussed at morning QA meetings which are held Monday through Friday. Any trends are examined during the monthly QA & A Committee meeting. Plans of action are established and recommendations acted upon.		

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	<p>Plan for Resolution: [Resident #39] used the bathroom and got cleaned up from there... So it was missed by mistake...."</p> <p>A "Resident/Family Concern Form," dated 5/13/13, indicated, "...[Resident #39's] hair smelled, hadn't been showered... Plan for Resolution: DoN [Director of Nursing] to check Monday and Thursdays for showers... Staff to be inserviced...."</p> <p>3.1-3(l)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop an initial plan of care for a 1 of 10 residents reviewed for unnecessary medications [Resident #51] and failed to develop a coordinated hospice care plan for 1 of 1 resident reviewed for hospice services [Resident #49].</p> <p>Findings include:</p> <p>1. On 5/16/13 at 9:46 A.M., Resident #51's record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation,</p>	F000279	It is the policy of this facility to develop an initial plan of care for all residents upon admission that identifies immediate assessed medical, nursing, and mental and psychosocial needs of the resident, as well as measurable outcome objectives. It is the policy and standard practice of the facility to develop a comprehensive interdisciplinary care plan, within 7 days of completion of the MDS, which includes coordination with hospice staff, for all residents receiving hospice services.1. Describe what the facility did to correct the deficient practice for	06/16/2013	

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	<p>depression, pain [status post cystitis], and diabetes. Resident #51 was admitted to the facility on 5/5/13.</p> <p>A "Physician's Orders," dated 5/1/13 through 5/31/13, indicated Resident #51 was prescribed the following medications: Coumadin [anti-coagulant, used for treatment of atrial fibrillation], Fentanyl [pain medication], Lantus [used for treatment of diabetes], and Citalopram [anti-depressant].</p> <p>An "Initial Care Plan," dated 5/5/13, indicated, "...Problem: Safety..., Nutritional related to diabetes... Will consume greater than 80% of meal... Monitor intake and output. Provide diet as ordered..." The care plan did not address pain medications and/or psychotropic medications and non-pharmacological interventions and did not address risks associated with Coumadin use or insulin use.</p> <p>A "Potential for alteration in nutritional status and fluid balance Care Plan," dated 5/12/13, indicated, "...Related to: Obesity, Difficulty chewing, PO [oral] intake less than 75%, Abnormal nutrition/fluid related labs: Glucose, Depression...." The care plan did not address pain medications and/or psychotropic medications and</p>		<p>each client cited in the deficiency. The Care Plans for Resident #51 have been developed to include diagnosis of Atrial Fibrillation, Coumadin usage, diabetes, antidepressant medication usage, and pain. Per facility policy and procedure, a Coumadin flow form has been initiated to track PT/INR, current dosage, and Physician order changes. Anti-depressants are monitored on the Anti-psychotropic drug monitoring form which is also being utilized.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All new admission charts are brought to the morning QA meeting which meets Monday through Friday. The content of the admission packet, which includes the Initial Care Plan, is reviewed by all department heads to assure all appropriate interventions and monitoring forms are in place. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Licensed staff will be re-educated by 6-14-13 by Nursing Administration regarding</p>				

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	<p>non-pharmacological interventions and did not address risks associated with Coumadin use or insulin use.</p> <p>On 5/18/13 at 11:00 A.M., in an interview, the Director of Nursing [DoN] indicated the facility did not develop a care plan for Resident #51 in regard to her Coumadin, Fentanyl, Lantus, and Citalopram use. She indicated the MDS [Minimum Data Set] coordinator had until next week to complete Resident #51's care plans. There was no documentation in Resident #51's clinical record related to monitoring the potential side effects of the medications.</p>		<p>completion of the Initial Care Plan and implementing the appropriate monitoring forms when a resident is admitted. Department heads will be re-educated by the Nurse Consultant by 6-14-13 regarding review of the contents of a new admission chart, the Initial Care Plan, and appropriate monitoring forms. The medical records designee will audit all newly admitted charts within 48hr. then weekly, then quarterly ongoing 4. Describe 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. The chart audits will be brought to the QA &amp; A Committee meeting on a monthly basis. Recommendations regarding results of the audits will be at the discretion of the Committee. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Hospice was notified of the deficient practice and an Interdisciplinary Care Plan meeting has been scheduled. The Hospice Aide has regularly scheduled assignment days for providing resident care. This information was added to the Care Plan and the facility C.N.A. care guide on 5-31-13. In the event the Hospice Aide has a change in the schedule, the facility will be notified at least 24hr. in advance. Any further changes to the Hospice Aide</p>		

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			<p>schedule will be conveyed to the DON via the Hospice Nurse. The Care Plan and care guide will be revised as appropriate. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All Hospice residents have the potential to be affected. There are currently no other Hospice residents in the facility. However, in the future if a Hospice resident is admitted, the Hospice Agency will be notified by the Social Service Designee of the facility procedure regarding Interdisciplinary Care Plan Meetings which would require the presence of the Hospice Nurse as well as establishing scheduled times the Hospice Aide would be caring for the resident. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made. The SSD, as well as other Department Heads which attend the care plan meetings, will be re-educated by the Nurse Consultant by 6-14-13 regarding Interdisciplinary Care Plans which will include the Hospice Nurse. The current Hospice Agency will be notified by the DON of the facility</p>		

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	<p>2. Resident #49's record was reviewed on 5/16/2013 at 10:36 A.M. Resident #49 had diagnoses, which included but were not limited to, dementia, lung nodules, and dysphagia. A history and physical dated 3/17/2013, indicated, Resident #49 was admitted to the facility for hospice and respite care.</p> <p>Review of a current CNA assignment sheet provided by LPN #100 on</p>		<p>requirements of attending the Care Clan meetings, as well as establishing set schedules for the Hospice Aide and required notification of any changes to the schedule. In the event other Hospice residents are admitted, the DON will contact the Hospice Agency and educate them as to the facility requirements. 4. Describe 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 in place. Residents who have had a scheduled Care Plan during the month will be reviewed by the MDS Coordinator prior to the monthly QA &amp; A Committee meeting to assure the Care Plan was interdisciplinary and that the Hospice care schedule is included in the care plan. Results of the review will be discussed at the meeting every month for 3 months. Further review will be at the discretion of the Committee.</p>		

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	<p>5/16/2013 at 10:43 A.M., indicated, Resident #49 had "Hospice."</p> <p>During an interview on 5/16/2013 at 10:43 A.M., LPN (Licensed Practical Nurse (LPN) #100 indicated, the facility did not have an integrated care plan which included specific interventions to be provided to Resident #100 by hospice versus the facility. LPN #100 indicated, the CNAs (Certified Nursing Assistants) had assignment sheets instructing them about hospice care. Review of a current CNA assignment sheet provided by LPN #100 indicated, under important information, Resident #49 had, "Hospice." LPN #100 indicated, she thought Hospice came in on Thursdays and the Hospice Aides gave him showers on Monday and Friday with bed bathes given on Tuesday. She further indicated, she wasn't sure because they switched it recently and they communicated verbally in regards to care.</p> <p>A policy titled, "Hickory Creek Healthcare Foundation, Inc. Hospice Care", was reviewed on 5/17/2013 at 2:00 P.M. This policy indicated, ". . . Integrate Hospice's plan of care into resident's comprehensive care plan. . ."</p>			

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	3.1-35(a) 3.1-35(d)(2)(A)			

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F000282 SS=E	<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 ensure care and services were provided to residents in accordance with their written plans of care. This deficient practice affected 3 of 5 residents reviewed for services being provided per plan of care (Resident #36, #39, and #32).</p> <p>Findings:</p> <p>1. Resident #36's record was reviewed on 5/16/2013 at 9:41 A.M. Resident #36 had diagnoses, which included but were not limited to, anxiety, depression, and a history of falls.</p> <p>During an interview on 5/13/2013 at 1:53 P.M., LPN (Licensed Practical Nurse) #100 indicated, Resident #36 had fallen within the past 30 days.</p> <p>A document titled, "Episodic Care Plan dated 5/15/2013, indicated Resident #36 had a history of falls and recently fell due to weakened bilateral lower extremities. This care</p>	F000282	<p>It is the practice of this facility to ensure care and services are provided by qualified persons in accordance with each resident's written plans of care. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Cna #101 was immediately educated of change in resident's care plan. On 5-16-13 the Cna care guide was updated, specifying resident #36 as a 2 person assist. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents in the facility have the potential to be affected by this deficient practice. Cna care guides will be audited to ensure they correlate with all resident plans of care, including episodic care plans, by 6-14-13. Corrections will be made as necessary based on the audit results of care plans, episodic care plans, and Cna care guides. Updated Cna care guides will be distributed. 3. Describe the steps or systemic changes the facility</p>	06/16/2013			

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	<p>plan indicated Resident #36 was at risk for additional falls due to weakness and goals to prevent additional falls included providing the assistance of two for transfers.</p> <p>During an observation on 5/16/2013 at 12:42 P.M., CNA (Certified Nursing Assistant) #101 was observed pushing Resident #36 in a wheelchair to the restroom. At 12:46 P.M., CNA #101 was observed wheeling Resident #36 out of the restroom. During an interview at this time, CNA #101 indicated, she assisted Resident #101 to the restroom alone because it was her understanding Resident #36 only needed one person to transfer.</p>		<p>has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. DON or designee will educated all nurses regarding the procedure of updating the Cna care guide when an episodic care plan is initiated by 6-14-13. In addition, the facility's Falls Checklist Worksheet has been updated to include updating Cna care guides when changes in interventions result from an episodic care plan. 4. Describe 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. Completed Falls Checklist Worksheets will be reviewed by the Interdisciplinary Team with each fall during morning QA meetings which are held Monday through Friday. Cna care guides will be checked at that time to ensure updates have been made as necessary. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #39's medication orders have been reviewed by Physician and DON. All orders are current. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client</p>		

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			<p>the facility identified as being affected. All residents in the facility have the potential to be affected by this deficient practice. Licensed personnel will review all residents' medication orders by 5-31-13 to ensure complete accuracy. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Nurses will be re-educated by Nursing Administration regarding the procedure of attaching a copy of all physician telephone orders to the 24-hour report by 6-14-13. All telephone orders will be reviewed during daily QA meetings at least 5 times weekly. Medication administration records will then be reviewed to ensure accurate transcription occurred. 4. Describe 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. A physician order audit sheet will be completed at least 5 times weekly for 30 days. Physician orders and medication records will be audited monthly thereafter. Results of audits will be presented during monthly QA &amp; A Committee meetings for further discussion and recommendations. 1. Describe what the facility did to correct the</p>	

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			<p>deficient practice for each client cited in the deficiency. Resident #39's Monday and Thursday weekly shower schedule is being followed. Nursing staff was in-serviced on 5-29-13 regarding the importance of documenting shower refusals. Facility will notify resident's wife of any refusals.2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.All residents in the facility require a level of assistance with showers and have the potential to be affected by this deficiency. Shower Sheets are being audited by DON or designee at least 5 times per week to ensure showers are being given as scheduled. Any discrepancies will be addressed by DON or designee and corrective action taken. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Nursing staff was in serviced on 5-15-13 and 5-29-13 regarding resident ADL care, including the process to be followed when a resident refuses care. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>		

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			i.e., what quality assurance program will be put into placeSocial Service Designee has been reassigned as Resident #39's Guardian Angel. Daily checks, ensuring the resident is receiving necessary assistance with ADL care, will be made 5 times per week and results discussed during daily QA meetings. Social Service or Designee will speak with Resident's wife at least weekly x3 months to ensure there are no additional concerns regarding resident's ADL care. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #32's porta cath was flushed by licensed personal on 5-17-13 per Physician order. The Physician and family were notified of the medication error which occurred during the month of April.2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All Residents' Physician orders and treatment record will be reviewed by 5-31-13 and monthly thereafter. The DON/designee will review the treatment record on a weekly basis to assure Physician orders are being followed and treatments are administered per order. Any		

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	2. On 5/16/13 at 1:03 P.M., Resident #39's record was reviewed. Diagnoses included, but were not limited to, cognitive decline, hypotension, bi-polar disease, hepatitis, insomnia, anxiety, and		treatments not being performed will be corrected immediately and the nurse responsible for the treatment will be re-educated with possible disciplinary action.3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The licensed staff were re-educated by Nursing Administration on 6-5-13 regarding following Physician orders and administration of treatments. The Physician orders are reviewed at the morning QA meetings Monday through Friday and also reviewed monthly. The treatment record is audited weekly by the DON/designee to assure all treatments are administered per Physician order. 4. Describe 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.The results of the auditing will be reviewed at the monthly QA & A Committee meetings. Any recommendations will be discussed with the Committee.		

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	<p>depression.</p> <p>A pharmacy recommendation, dated 4/10/2013, indicated Resident #39 should be considered for a gradual dose reduction of Seroquel. The record indicated Resident #39 Seroquel dose was increased on 1/23/2013 to 200 mg.</p> <p>A physician's orders, dated 4/11/13, indicated, "...Seroquel [anti-psychotic medication] decrease (from 200 mg at bedtime) to 150 milligrams [mg]...."</p> <p>A physician's orders, dated 4/29/13, indicated, "...Decrease Seroquel 150 mg...."</p> <p>A medication administration record [MAR], dated 4/1/13 through 4/30/13, indicated Seroquel 150 mg was started on 4/29/13. There was no documentation that Resident #39's Seroquel was decreased on 4/11/13.</p> <p>On 5/18/13 at 11:00 A.M., the Director of Nursing [DoN] indicated she was aware of the missed order on 4/11/13 as a result the physician re-wrote the order on 4/29/13 for the Seroquel to be decreased to 150 mg as a recommendation from the pharmacist.</p>						

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	<p>On 5/14/13 at 1:51 P.M., in an interview, Resident #39's wife indicated she was upset about her husband [Resident #39] not receiving his scheduled showers as evidenced by his unpleasant odor and unshaven appearance at times. She indicated she had spoken to the Administrator on several occasions regarding Resident #39's cleanliness and grooming.</p> <p>On 5/16/13 at 1:03 P.M., Resident #39's record was reviewed. Diagnoses included, but were not limited to, cognitive decline, hypotension, bi-polar disease, hepatitis, insomnia, anxiety, and depression.</p> <p>An "Activities of Daily Living [ADL] Care Plan," dated 4/4/12 indicated, "...I require extensive staff assistance with completing my daily care/needs... I will receive staff assistance daily to complete my adl tasks to be groomed and dressed daily through next review... I am to receive assistance with showers twice per week, I am to receive bed baths daily between shower days...."</p> <p>On 5/18/13 at 12:00 P.M., Resident #39's "Shower Day Skin Audit" sheets were received from the Director of</p>						

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	<p>Nursing [DoN]. At that time, she indicated a CNA [Certified Nursing Aide] completed the sheet when the resident received or was offered their shower.</p> <p>The record indicated that showers were not given as scheduled to Resident #39. The record indicated Resident #39 did not receive 2 of 8 scheduled showers in February 2013 and did not receive 6 of 8 scheduled showers in March 2013 and did not receive 4 of 10 scheduled showers in April 2013.</p> <p>3. During an observation on 5/17/13 at 2:27 p.m., Resident #32's porta catheter was observed in the right midline chest.</p> <p>The clinical record for Resident #32 was reviewed on 5/15/13 at 9:27 a.m. Diagnoses included, but were not limited to: CAD (Coronary Artery Disease), HTN (Hypertension), Atrial Fibrillation, COPD (Chronic Obstructive Pulmonary Disease), GERD (Gastroesophageal Reflux Disease), colon carcinoma, breast</p>			

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	<p>carcinoma, spinal cord ischemia, decubs, CHF(Chronic Heart Failure), paraplegia, neurogenic bladder with suprapubic catheter, multidrug resistant uti (urinary tract infection).</p> <p>A physician's orders dated 3/12/13 indicated, "Flush porta cath with 10cc (cubic centimeters) ns (normal saline) followed by 5 cc heparin solution of 100 u (units) heparin per 1 ml (milliliter) 1 x per month during non use to maintain patency.</p> <p>The Medication Administration Record (MAR), dated 04/2013, did not indicate the porta catheter had been flushed during April 2013. Documentation on the May 2013 treatment book indicated the porta catheter had been flushed on 5/12/13 by LPN #60. The record did not indicate a care plan for the porta catheter.</p> <p>During an interview on 5/16/13 at 9:12 a.m., LPN #60 indicated Resident #32's porta catheter was located in the left subclavian (beneath the clavical) area. LPN #60 indicated she did not know why the resident had the porta catheter and she further indicated there were no physician orders relating to the care and maintenance of the catheter on the</p>						

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	<p>resident's MAR, therefore, it had not been accessed (flushed) since 3/12/13.</p> <p>During an interview on 5/16/13 at 10:07 a.m., the DON indicated the porta catheter had not been accessed (flushed) because there were no orders on the resident's MAR. The DON the stated, "The site is just left alone if it is not being used."</p> <p>During a telephone interview on 5/17/13 at 12:24 p.m. with LPN #60, she indicated she did not flush the porta catheter on 5/12/13 and indicated she initialed the treatment book in error.</p> <p>During a phone interview with the physician's office on 5/17/13 at 3:30 p.m., staff member #73 indicated the porta catheter site was in the right midline chest and a defibrillator was located in the left chest.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 interview, and record review, the facility failed to ensure staff provided recommended care to a porta catheter for 1 of 1 residents reviewed for porta catheters (Resident # 32).</p> <p>Findings include:</p> <p>During an observation on 5/17/13 at 2:27 p.m., Resident #32's porta catheter was observed in the right midline chest.</p> <p>The clinical record for Resident #32 was reviewed on 5/15/13 at 9:27 a.m. Diagnoses included, but were not limited to: CAD (Coronary Artery Disease), HTN (Hypertension), Atrial Fibrillation, COPD (Chronic Obstructive Pulmonary Disease), GERD (Gastroesophageal Reflux Disease), colon carcinoma, breast carcinoma, spinal cord ischemia, decubs, CHF(Chronic Heart Failure), paraplegia, neurogenic bladder with suprapubic catheter, multidrug</p>	F000309	It is the policy of this facility to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with their comprehensive assessment and plan of care. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #32's porta cath was flushed by licensed personal on 5-17-13 per Physician order. The Physician and family were notified of the medication error which occurred during the month of April. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All Residents' Physician orders and treatment record will be reviewed by 5-31-13 and monthly thereafter. The DON/designee will review the treatment record on a weekly basis to assure Physician orders	06/16/2013			

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	<p>resistant uti (urinary tract infection).</p> <p>A physician's orders dated 3/12/13 indicated, "Flush porta cath with 10cc (cubic centimeters) ns (normal saline) followed by 5 cc heparin solution of 100 u (units) heparin per 1 ml (milliliter) 1 x per month during non use to maintain patency.</p> <p>The Medication Administration Record (MAR), dated 04/2013, did not indicate the porta catheter had been flushed during April 2013. Documentation on the May 2013 treatment book indicated the porta catheter had been flushed on 5/12/13 by LPN #60.</p> <p>During an interview on 5/16/13 at 9:12 a.m., LPN #60 indicated Resident #32's porta catheter was located in the left subclavian (beneath the clavical) area. LPN #60 indicated she did not know why the resident had the porta catheter and she further indicated there were no physician orders relating to the care and maintenance of the catheter on the resident's MAR, therefore, it had not been accessed (flushed) since 3/12/13.</p> <p>During an interview on 5/16/13 at 10:07 a.m., the DON indicated the</p>		<p>are being followed and treatments are administered per order. Any treatments not being performed will be corrected immediately and the nurse responsible for the treatment will be re-educated with possible disciplinary action. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The licensed staff were re-educated by Nursing Administration on 6-5-13 regarding following Physician orders and administration of treatments. The Physician orders and treatment record will be reviewed on a weekly basis by the DON/designee to assure all treatments are administered per Physician order. 4. Describe 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. The results of the auditing will be reviewed at the monthly QA &amp; A Committee meetings. Any recommendations will be discussed with the Committee.</p>		

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	<p>porta catheter had not been accessed (flushed) because there were no orders on the resident's MAR. The DON the stated, "The site is just left alone if it is not being used."</p> <p>During a telephone interview on 5/17/13 at 12:24 p.m. with LPN #60, she indicated she did not flush the porta catheter on 5/12/13 and indicated she initialed the treatment book in error.</p> <p>3.1-37 (a)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to provide the care and assistance needed to meet the cleanliness and grooming needs of a resident who required extensive assistance. This deficient practice affected 2 of 3 residents reviewed for Activities of Daily Living, Cleanliness, and Grooming in a sample of 5 residents [Resident #39 and #21].</p> <p>Findings include:</p> <p>1. On 5/14/13 at 1:51 P.M., in an interview, Resident #39's wife indicated she was upset about her husband [Resident #39] not receiving his scheduled showers as evidenced by his unpleasant odor and unshaven appearance at times. She indicated she had spoken to the Administrator on several occasions regarding Resident #39's cleanliness and grooming.</p> <p>On 5/16/13 at 1:03 P.M., Resident #39's record was reviewed. Diagnoses included, but were not</p>	F000312	<p>It is the policy of this facility to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #39's Monday and Thursday weekly shower schedule is being followed. Nursing staff was in-serviced on 5-29-13 regarding the importance of documenting shower refusals. Facility will notify resident's wife of any refusals. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents in the facility require a level of assistance with showers and have the potential to be affected by this deficiency. Shower Sheets are being audited by DON or designee at least 5 times per week to ensure showers are being given as scheduled. Any discrepancies will be addressed</p>	06/16/2013

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	<p>limited to, cognitive decline, hypotension, bi-polar disease, hepatitis, insomnia, anxiety, and depression.</p> <p>An "Activities of Daily Living [ADL] Care Plan," dated 4/4/12 indicated, "...I require extensive staff assistance with completing my daily care/needs... I will receive staff assistance daily to complete my adl tasks to be groomed and dressed daily through next review... I am to receive assistance with showers twice per week, I am to receive bed baths daily between shower days...."</p> <p>On 5/18/13 at 12:00 P.M., Resident #39's "Shower Day Skin Audit" sheets were received from the Director of Nursing [DoN]. At that time, she indicated a CNA [Certified Nursing Aide] completed the sheet when the resident received or was offered their shower.</p> <p>The record indicated that showers were not given as scheduled to Resident #39. The record indicated Resident #39 did not receive 2 of 8 scheduled showers in February 2013 and did not receive 6 of 8 scheduled showers in March 2013 and did not receive 4 of 10 scheduled showers in April 2013.</p>		<p>by DON or designee and corrective action taken. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Nursing staff was in serviced on 5-15-13 and 5-29-13 regarding resident ADL care, including the process to be followed when a resident refuses care. 4. Describe 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. Social Service Designee has been reassigned as Resident #39's Guardian Angel. Daily checks, ensuring the resident is receiving necessary assistance with ADL care, will be made 5 times per week and results discussed during daily QA meetings. Social Service or Designee will speak with Resident's wife at least weekly x3 months to ensure there are no additional concerns regarding resident's ADL care. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #21 had his nails trimmed and cleaned on 5-18-13. In the future his nails will be cleaned and trimmed during his scheduled shower days and any time as needed. This will be per professional standard by the</p>				

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			<p>licensed staff. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Cleaning and trimming resident nails are part of daily ADL care as well as a part of the shower procedure. All residents' nails were assessed by Guardian Angels and will become part of the Guardian Angel rounds as well as a daily duty of the Charge Nurse. Any resident who requires nail care will be attended to by the C.N.A. unless their diagnosis requires licensed staff to perform the care. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Nursing staff were re-educated by Nursing Administration on 6-5-13 regarding nail care and whose responsibility it is to perform the care. Nail care is also listed on the nursing weekly skin assessments. The Guardian Angel rounds tool has been revised to include an assessment of nails. The Administrator has re-educated the Guardian Angels regarding the update. 4. Describe how the corrective action(s) will be monitored to ensure the</p>		

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	<p>2. Resident #21's record was reviewed on 5/16/2013 at 10:50 A.M. Resident #21 had diagnoses which included, but were not limited to, diabetes, depressive disorder, cerebral vascular accident (stroke) with left sided hemi-paresis, and mental retardation.</p> <p>During observations on 5/13/2013 at 2:10 P.M. and 5/16/2013 at 10:23 A.M., Resident #21 had long, jagged edged nails, with a brown substance in his nail beds.</p> <p>A quarterly Minimum Data Set Assessment tool (MDS), dated 4/10/2013, indicated, Resident #21 required extensive assistance with completing activities of daily living (ADLs) related to his left hand was contracted.</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place. The Guardian Angel rounds form will be reviewed on a daily basis Monday through Friday to identify any area of concerns. The rounds form is also reviewed at the monthly QA &amp; A Committee meeting to assure resident care items are being addressed. Any recommendations to the rounds tool and its results will be at the discretion of the Committee.</p>	

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	<p>During an interview on 5/16/2013 at 2:30 P.M., the DON (Director of Nursing), Administrator, and the Assistant Administrator were informed of the observations made of Resident #21's nails. At this time, documentation Resident 21's nail care was requested. The DON indicated she assumed nail care was being done during shower care.</p> <p>During an interview on 5/17/2013 at 10:10 A.M., the DON indicated, the facility did not have documentation which indicated care had been provided to Resident #21's fingernails.</p> <p>3.1-38(a)(3)(A)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident received adequate assistance to prevent accidents for 1 of 5 residents reviewed for falls (Resident #36).</p> <p>Findings include:</p> <p>Resident #36's record was reviewed on 5/16/2013 at 9:41 A.M. Resident #36 had diagnoses, which included but were not limited to, anxiety, depression, and a history of falls.</p> <p>During an interview on 5/13/2013 at 1:53 P.M., LPN (Licensed Practical Nurse) #100 indicated, Resident #36 had fallen within the past 30 days.</p> <p>A document titled, "Episodic Care Plan dated 5/15/2013, indicated Resident #36 had a history of falls and recently fell due to weakened bilateral lower extremities. This care plan indicated Resident #36 was at risk for additional falls due to weakness and goals to prevent</p>	F000323	<p>It is the policy of this facility to ensure each resident receives adequate supervision, assistance, and assistance devices to prevent accidents. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Cna #101 was immediately educated of change in resident's care plan. On 5-16-13 the Cna care guide was updated, specifying resident #36 as a 2 person assist. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents in the facility have the potential to be affected by this deficient practice. Cna care guides will be audited to ensure they correlate with all resident plans of care, including episodic care plans, by 6-14-13. Corrections will be made as necessary based on the audit results of care plans, episodic care plans, and Cna care guides. Updated Cna care guides will be distributed. 3. Describe the steps or systemic changes the</p>	06/16/2013			

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	<p>additional falls included providing the assistance of two for transfers.</p> <p>During an observation on 5/16/2013 at 12:42 P.M., CNA (Certified Nursing Assistant) #101 was observed pushing Resident #36 in a wheelchair to the restroom. At 12:46 P.M., CNA #101 was observed wheeling Resident #36 out of the restroom. During an interview at this time, CNA #101 indicated, she assisted Resident #101 to the restroom alone because it was her understanding Resident #36 only needed one person to transfer.</p> <p>3.1-45(a)(2)</p>		<p>facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. DON or designee will educated all nurses regarding the procedure of updating the Cna care guide when an episodic care plan is initiated by 6-14-13. In addition, the facility's Falls Checklist Worksheet has been updated to include updating Cna care guides when changes in interventions result from an episodic care plan. 4. Describe 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. Completed Falls Checklist Worksheets will be reviewed by the Interdisciplinary Team with each fall during morning QA meetings which are held Monday through Friday. Cna care guides will be checked at that time to ensure updates have been made as necessary.</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a physician's order to decrease an anti-psychotic medication [Seroquel] was followed for 19 days. This deficient practice affected 1 of 10 residents reviewed for unnecessary medication use [Resident #39].</p> <p>Findings include:</p> <p>On 5/16/13 at 1:03 P.M., Resident #39's record was reviewed.</p>	F000329	<p>It is the policy of this facility to ensure each resident's drug regimen is free from unnecessary drugs. It is the standard practice of this facility to ensure all physicians' orders are followed.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #39's medication orders have been reviewed by Physician and DON. All orders are current. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient</p>	06/16/2013			

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	<p>Diagnoses included, but were not limited to, cognitive decline, hypotension, bi-polar disease, hepatitis, insomnia, anxiety, and depression.</p> <p>A pharmacy recommendation, dated 4/10/2013, indicated Resident #39 should be considered for a gradual dose reduction of Seroquel. The record indicated Resident #39 Seroquel dose was increased on 1/23/2013 to 200 mg.</p> <p>A physician's orders, dated 4/11/13, indicated, "...Seroquel [anti-psychotic medication] decrease (from 200 mg at bedtime) to 150 milligrams [mg]...."</p> <p>A physician's orders, dated 4/29/13, indicated, "...Decrease Seroquel 150 mg...."</p> <p>A medication administration record [MAR], dated 4/1/13 through 4/30/13, indicated Seroquel 150 mg was started on 4/29/13. There was no documentation that Resident #39's Seroquel was decreased on 4/11/13.</p> <p>On 5/18/13 at 11:00 A.M., the Director of Nursing [DoN] indicated she was aware of the missed order on 4/11/13 as a result the physician re-wrote the order on 4/29/13 for the</p>		<p>practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents in the facility have the potential to be affected by this deficient practice. Licensed personnel will review all residents' medication orders by 5-31-13 to ensure complete accuracy. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Nurses will be re-educated by 6-14-13 regarding the procedure of attaching a copy of all physician telephone orders to the 24-hour report. All telephone orders will be reviewed during morning QA meetings at least 5 times weekly. Medication administration records will then be reviewed to ensure accurate transcription occurred. 4. Describe 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. A physician order audit sheet will be completed at least 5 times weekly for 30 days. Physician orders and medication records will be audited monthly thereafter. Results of audits will be presented during monthly QA &amp; A Committee meetings for further discussion and</p>		

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	Seroquel to be decreased to 150 mg as a recommendation from the pharmacist.  3.1-48(a)(1)		recommendations.	

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 Based on observation, interview, and record review, the facility failed to label food with a preparation or "use by" date and failed to secure clothing to prevent cross contamination of food being served in 1 of 1 kitchen. This deficient practice affected 34 of 35 residents who receive food from the kitchen.</p> <p>Findings include:</p> <p>On 5/13/13 at 9:50 A.M., tour of the kitchen was initiated with the Dietary Manager. At that time the following was observed:</p> <p>Refrigerator #1:</p> <p>A. 10 small dishes of lemon glazed fruit without a preparation or use by date.</p> <p>B. 1 tray of cottage cheese without a preparation or use by date.</p> <p>Walk-In Refrigerator:</p>	F000371	<p>It is the policy of this facility to store, prepare, distribute, and serve food under sanitary conditions. This includes labeling food items with a preparation or "use by" date and ensuring that all staff secure clothing in order to prevent cross contamination of food being served 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 5-21-13, all members of the dietary staff were in-serviced on Facility's Date Marking policy by the Dietary Manager and Assistant Administrator. On 5-29-13, Dietary Manager re-educated dietary staff on kitchen dress code. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents that receive food from the kitchen have the potential to be affected by this deficiency. On 5-21-13, all members of the dietary staff were in-serviced on Facility's Date</p>	06/16/2013

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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
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	<p>C. 28 cups of orange juice without a preparation or use by date.</p> <p>D. 22 cups of white milk without a preparation or use by date.</p> <p>E. 8 cups of chocolate milk without a preparation or sue by date.</p> <p>F. 9 large cups of specialty juices [thickened] without a preparation or use by date.</p> <p>On 5/13/13 at 10:00 A.M., in an interview, the Dietary Manager indicated staff were aware all prepared foods/drinks needed a date of preparation or use by date.</p> <p>On 5/13/13 at 11:43 A.M., Dietary Aide #21 was observed serving food from the steam table. She had an apron on; however, her strings from her jacket were loose and observed hanging over the food, touching the mashed potatoes while she was bending over to scoop the food item.</p> <p>On 5/17/13 at 1:55 P.M., the Assistant Administrator provided the "Date Marking" policy and procedure, dated 2009. The policy and procedure indicated, "...All prepared foods that are stored will be properly</p>		<p>Marking policy by the Dietary Manager and Assistant Administrator. On 5-29-13, Dietary Manager conducted an in-service for dietary staff regarding kitchen dress code. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. On 5-21-13, a date marking audit sheet was initiated, and staff in-serviced on its use. The AM and PM cooks were assigned the task of checking all foods in the reach-in refrigerator, reach-in freezer, and walk-in cooler to ensure all items are properly labeled and dated. Cooks then initial the audit-sheet to ensure they have checked for compliance. 4. Describe 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. Dietary Manager will review the date labeling audit sheet, as well as conduct date and labeling checks for items in the refrigerator, freezer, and cooler at least 5 times per week. Any staff member found to be out of compliance with facility's dress code will be immediately sent home to change. Progressive disciplinary action will be taken as necessary.</p>		

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	<p>dated to ensure food safety...." At that time, in an interview, the Assistant Administrator, Administrator, and Director of Nursing [DoN] indicated loose clothing should not be worn in the kitchen area related to cross contamination of food.</p> <p>3.1-21(i)(2)</p>			

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000441	It is the policy and standard practice of this facility to maintain	06/16/2013			

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	<p>follow infection control practices related to lack of hand washing prior to providing assistance with feeding [Resident #3] during 1 of 1 dining observation.</p> <p>Findings include:</p> <p>On 5/13/13 at 12:15 P.M., Certified Nursing Aide [CNA] #20 was observed delivering room trays to residents. At that time, she indicated Resident #3 required assistance with feeding; therefore, she would pass his tray last. CNA #20 failed to wash or sanitize her hands prior to assisting Resident #3 with his meal.</p> <p>On 5/17/13 at 12:05 P.M., in an interview, the Director of Nursing [DoN] indicated staff were inserviced on hand hygiene and expected to wash their hands prior to assisting a resident with meals. At that time, she provided the "Hand Cleanser" policy and procedure, dated 6/2004. The policy and procedure indicated, "...To cleanse hands between resident contacts during medication administration and/or meal services... Hands should be washed with soap and water after direct resident contact... Personnel should always wash their hands before preparing food...."</p>		<p>the established infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. This includes requiring that staff wash their hands when indicated by accepted professional practice. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 5-15-13 and 5-29-13, nursing staff was in-serviced on policy and procedure for appropriate times for hand washing along with repercussions of improper infection control and cross contamination. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by this practice. The DON and other managers will observe for appropriate hand washing practice on the part of all staff as part of their routine, frequent rounds throughout the facility. If inappropriate hand washing or lack of hand washing is observed, the employee will be stopped at that time, and instructed on proper hand washing. Once this has been completed, and the resident is cared for, the DON/designee will</p>	

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	3.1-18(l)		follow up with the employee involved. Progressive disciplinary action will be rendered for continued noncompliance. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In addition to the in-services conducted on 5-15-13 and 5-29-13, hand washing skills check offs will be completed 5 times weekly for two weeks observed by the DON/designee. Upon completion of the skill check offs, all nursing personnel will have demonstrated consistent use of proper technique and be able to verbalize appropriate times for hand hygiene per facility policy and procedures. Random check offs will continue weekly times two months. All newly hired nursing personnel will complete hand washing skills check off. Any identified concerns in hand washing will be addressed as outlined in question #2. 4. Describe 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. The DON will bring the results of the hand washing observations and return demonstrations to the monthly QA & A Committee meetings for further review, discussion, and		

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			follow-up. Any recommendations made by the Committee will be followed up by the DON who will then report results at the next scheduled Committee meeting. This will continue on an on-going basis.	