

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155699	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER BRIDGEWATER REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 30, 31, and April 1, 4, and 5, 2016.</p> <p>Facility number: 000290 Provider number: 155699 AIM number: 100379970</p> <p>Census bed type: SNF/NF: 23 Total: 23</p> <p>Census payor type: Medicare: 1 Medicaid: 21 Other: 1 Total: 23</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on April 8, 2016 by 17934.</p>	F 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the state of deficiencies or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests that our date of compliance be on or after April 13, 2016.</p> <p>Provider requests that we are able to achieve paper compliance in lieu of a revisit.</p> <p>Respectfully submitted, James D. Sizemore, HFA Administrator</p>	
F 0241	483.15(a)			

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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SS=E Bldg. 00	<p>DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident received a shower in a dignified manner for 1 of 23 residents (Resident #29). This deficient practice had the potential to affect 23 of 23 residents who received showers in the shower room. The facility also failed to ensure residents were served and assisted with meals in a dignified manner (Residents #2, 35, & 9).</p> <p>Findings include:</p> <p>1.) During an observation on 4/4/16 at 1:44 p.m., the Administrator knocked on the door and entered the shower room after Certified Nursing Assistant (CNA) #11 stated "resident care". As the Administrator was exiting the shower room, the Activity Director (AD) walked into the shower room and stated, "I just need to wash my hands". The AD exited the shower room.</p> <p>During an observation on 4/4/16 at 1:52 p.m., CNA #11 exited the shower room with Resident #29 in a wheelchair, and</p>	F 0241	<p>F 241</p> <p>Residents #29, 2, 35, & 9 did not experience anynegative outcomes related to the alleged deficient practice. Resident #29 is receiving showers in adignified manner. Residents #2, 35,& 9 are receiving meals in a dignified manner.</p> <p>All residents have the potential to be affected and arecurrently receiving showers and meals in a dignified manner.</p> <p>The facility's Administrator, Activity Director and Nursingstaff, (including LPN #9 and CNA #8) have been re-educated on resident dignitywith a special focus on providing showers in a dignified manner (knocking ondoor, waiting for permission to enter, announcing yourself, & providingprivacy during care) and providing meals in a dignified manner with a specialfocus on involving the residents in conversations during meal times. A privacy sign has been implemented and isused on the shower room door to ensure no one enters during shower times. Also, managers will be observing meals toensure dignity is maintained. A monitoring tool has been implemented.</p>	04/15/2016

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	<p>indicated she just completed the resident's shower.</p> <p>During an interview on 4/4/16 at 2:02 p.m., the Administrator indicated he entered the shower room because the call light was going off. He also indicated the AD entered the shower room to wash her hands. He stated, "It's probably not the best practice to have" in regards to when the AD entered the shower room to wash her hands while a resident was showered.</p> <p>During an interview on 4/4/16 at 2:27 p.m., the Director of Nursing indicated all residents in the facility received showers in the shower room.</p> <p>During an interview on 4/4/16 at 3:10 p.m., the AD indicated she used the shower room to wash her hands because it was the closest. She further indicated Resident #29 had seen her enter the shower room, as she had laughed when she noticed she was in the room.</p> <p>Resident #29's clinical record was reviewed on 4/4/16 at 2:08 p.m. Resident #29's current diagnoses included, but were not limited to, dementia and major depressive disorder.</p> <p>Resident #29 had a current, 2/11/16, quarterly, Minimum Data Set (MDS)</p>		<p>The Administrator or Designee will be responsible for observing 2 resident showers and two meal service at alternate times of the day to ensure dignity is being maintained. These observations will occur on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>	

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	<p>assessment which indicated she was severely cognitively impaired and needed physical help with bathing.</p> <p>Review of a document titled, "STEPS, INITIAL AND FINAL - PROVISION OF CARE", dated 10/2014, and provided by the Director of Nursing (DON) on 4/5/16 at 9:04 a.m., included the following: "...knock and identify yourself before entering... Wait for permission to enter... 7. Close curtains, drapes, and doors...."</p> <p>2. During a dining observation in the main dining room, beginning on 4/1/16 at 11:27 a.m., the following was observed:</p> <p>Resident #9 was seated at a table facing the wall with CNA #8 seated to her right, facing toward the dining room. CNA #8 was assisting the resident with her meal.</p> <p>Resident #35 was seated at the next table, facing away from Resident #9 and CNA #8. His head was down and his meal was on the table in front of him.</p> <p>Resident #2 was seated to Resident #35's right, facing the wall. The Activity Director (AD) was seated to his right, facing toward the dining room, and was assisting the resident with his meal.</p> <p>LPN #9 approached Resident #35 and</p>			

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	<p>began assisting him with his meal.</p> <p>CNA #8 indicated Resident #2 was eating well and asked the AD if she had "fed" Resident #2 the day before. The AD indicated she had.</p> <p>CNA #8 then asked LPN #9 what staff members were working that evening, indicating Resident #35 was "hard to feed", and some staff had difficulty assisting Resident #35 with meals. LPN #9 asked Resident #35 to take a bite. LPN #9 and CNA #8 began discussing who was scheduled to come in at 2:00 p.m. that afternoon.</p> <p>LPN #9, CNA #8, and the AD then began discussing what they liked to mix in cottage cheese, and discussed growing tomatoes and what they would like to grow in their summer gardens.</p> <p>CNA #8 indicated Resident #9 was a "picky eater". LPN #9 indicated the resident liked her health shake. CNA #8 indicated she had mixed it in with Resident #9's ice cream and she had been drinking it. CNA #8 indicated to Resident #9 to take a bite. CNA #8 indicated Resident #9 did not seem to like her chocolate dessert. LPN #9 asked CNA #8 if Resident #9 had drank anything and indicated she liked milk.</p>			

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F 0323	<p>The AD then indicated Resident #2 "eats good". LPN #9 and CNA #8 indicated they agreed.</p> <p>LPN #9 asked CNA #8 if Resident #35 had laid down after breakfast. LPN #9 then indicated Resident #35 looked like he was ready for a nap.</p> <p>During an interview, on 4/1/16 at 3:04 p.m., CNA #8 indicated the residents who were "feeds" should be spoken to; she indicated Resident #9 did not always respond when spoken to. She further indicated Resident #2 could not talk and Resident #35 had been really tired that afternoon.</p> <p>During an interview, on 4/4/16 at 1:35 p.m., the AD indicated residents should be kept involved in conversations.</p> <p>On 4/4/16 at 2:54 p.m., the DON indicated maintaining resident dignity was a standard of care for the facility when asked if there was a policy regarding dignity while providing services to residents.</p> <p>3.1-3(t)</p> <p>483.25(h)</p>			

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SS=D Bldg. 00	<p>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <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. Based on observation, interview, and record review, the facility failed to ensure sharps were properly stored. This deficient practice had the potential to affect 1 of 1 ambulatory wandering resident (Resident #30).</p> <p>Findings included:</p> <p>During an observation made on the initial tour of the facility on 3/30/16 at 10:34 a.m., an unpackaged, uncovered three-bladed razor was on the bathroom shelf in Resident #15's room.</p> <p>During an interview with Resident #15 on 3/30/16 at 10:34 a.m., he indicated the bathroom shelf was where he kept his razor for "shaving up".</p> <p>During an interview on 3/31/16 at 1:38 p.m., the Administrator indicated there was not a specific policy regarding razors in residents' rooms. He also indicated he expected that a razor would be in a bedside table or somewhere out of sight in a cognitively intact resident's room.</p>	F 0323	<p>F 323</p> <p>Resident #30 did not experience any negative outcomes related to this alleged deficient practice. Razors are currently being properly stored in an attempt to prevent hazards.</p> <p>All wandering residents have the potential to be affected. A facility wide inspection has been completed and no razors were found. All razors are being properly stored in an attempt to prevent hazards.</p> <p>The facility's staff have been educated on hazards with a special focus on properly storing razors. A monitoring tool has been implemented.</p> <p>The DON or designee will be responsible for completing random observations to ensure hazards (including razors) are stored properly. These observations will occur on scheduled work days as follows: Two times weekly for four weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an</p>	04/15/2016
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F 0371 SS=E Bldg. 00	<p>During an interview on 3/31/16 at 2:00 p.m., the Assistant Director of Nursing (ADON) indicated there was one ambulatory wandering resident on that hallway (Resident #30).</p> <p>Resident #30's clinical record was reviewed on 4/1/16 at 8:46 a.m. Resident #30's current diagnosis included, but was not limited to, dementia.</p> <p>Resident #30 had a current, 2/10/16, quarterly, Minimum Data Set (MDS) assessment that indicated she was severely cognitively impaired and used a walker for mobility.</p> <p>Resident #30 had a 3/2/16 care plan problem that included, "...During moments of increased confusion Res [resident] will occasionally wander into other Res [residents'] rooms in an attempt to find hers..."</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or</p>		ongoing basis for a minimum of 6 months and the plan adjusted if indicated.	

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	<p>considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to ensure meal assistance was provided in a sanitary manner. This had the potential to affect 11 of 11 residents who were eating in the dining room during the first meal observation and 10 of 10 residents who were eating in the dining room on the second day of meal observation.</p> <p>Findings include:</p> <p>During a meal observation on 3/30/2016 at 11:35 a.m., the Activity Director (AD) was observed approaching Resident #2 who was sitting at the dining room table in his Broda chair. The AD removed a piece of bread from the plastic covering, held it with her bare hand and proceeded to butter the bread with a plastic knife. The AD then picked up a straw, removed the paper from the drinking end of the straw, touched the drinking end of the straw with her bare hands and placed it into a drink for Resident #2. Resident #2 then drank from the straw and ate the buttered bread.</p> <p>During a meal observation on 4/1/2016 at 11:27 a.m., the AD approached Resident #29 as she sat at the dining table. The</p>	F 0371	<p>F 371</p> <p>There were no residents affected by this alleged deficient practice including Residents #2 and 29. All residents are currently being served meals in a sanitary manner. The Activity Director was immediately educated on procedures for meal service with a special focus on not touching food with bare hands.</p> <p>All residents who eat meals have the potential to be affected. All residents are served meals in a sanitary manner. Staff have been educated on the procedures for meal service with a special focus on not touching food with bare hands.</p> <p>The facility has educated staff, including the Activity Director, on meal procedures with a special focus on not touching food with bare hands. Managers have been assigned to observe meals service to ensure meal service is completed in a sanitary manner. A monitoring tool has been implemented.</p> <p>The Administrator or designee will be responsible for observing two meal services to ensure meals are served in a sanitary manner. These observations will occur at alternating meal times on scheduled work days as follows: Daily for two weeks, weekly for two weeks,</p>	04/15/2016

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F 0431 SS=E Bldg. 00	<p>AD then placed her hand on a tortilla on Resident #29's plate and added toppings to it. She then picked up the tortilla and folded the ends and placed it back on the resident's plate. The AD then pulled a straw out of the wrapper by the drinking end, placed it into a drink for Resident #2 and offered the drink to Resident #2.</p> <p>During an interview with the AD on 4/4/2016 at 1:13 p.m., she indicated she had never received any training on how to assist a resident in the dining room.</p> <p>A current policy titled "Glove use & Meal Service" was dated 11/2014 and provided by the Director of Nursing on 4/4/2016 at 2:54 p.m., indicated the following: "Policy: In an effort to protect food products from contamination, all products should be served using utensils...Procedure:...4. Employees may not touch ready to eat foods with bare hand, gloves must be worn"</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p>		<p>monthly for two months then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were securely stored for 3 of 3 medications carts (Carts #1, #2, and #3).</p> <p>Findings include:</p>	F 0431	<p>F 431</p> <p>There were no residents affected by this alleged deficient practice but all have the potential to be affected. All of the medication carts have been cleaned and currently have no loose pills present.</p>	04/15/2016

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	<p>During an observation of medication storage, accompanied by LPN #9, beginning on 4/1/16 at 9:34 a.m., the following were observed:</p> <p>Medication cart #1 was observed to have one yellow caplet loose in the second drawer of the cart.</p> <p>Medication cart #2 was observed to have one white tablet loose in the second drawer of the cart. An aerosol bottle of air freshener and a pump bottle of air freshener were observed in the bottom drawer of the cart.</p> <p>Medication cart #3 was observed to have two small white tablets loose in the second drawer of the cart.</p> <p>LPN #9 indicated during the observation pills should not be loose in the cart.</p> <p>Review of a current policy titled, "Storing Drugs", dated 1/2015 and provided by the DON on 4/4/15 at 10:21 a.m., indicated the following: "...Drugs and biologicals will be stored in a safe, secure, and orderly manner...."</p> <p>3.1-25(m)</p>		<p>The facility has re-educated the nurses and QMAs on storage of medications with a special focus on not having loose pills in the medication carts. A monitoring tool has been implemented.</p> <p>The DON or designee will be responsible for completing audits of the medication carts to ensure there are no loose pills present. The audits will occur on scheduled work days as follows: weekly for three months then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>	

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F 0441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>			
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	<p>Based on observation, interview and record review the facility failed to serve food in a sanitary manner during meal service, carry clean resident linens away from their personal clothing and wash hands before and after personal care. Furthermore, the facility failed to ensure infection control practices were followed for intravenous nutrition administration. These deficient practices had the potential to effect 23 of 23 residents residing at the facility.</p> <p>Findings include:</p> <p>1. During an observation of catheter care with LPN #9 on 4/1/2016 at 2:30 p.m., she entered the resident room carrying an empty tub and supplies for catheter care. LPN #9 went into the bathroom, turned on the water, filled the tub with water, and then donned gloves. LPN #9 grabbed the bottle of soap with her gloved hand and squeezed the soap onto the wash cloth. LPN #9 provided catheter care, removed the soiled gloves and emptied the tub of water into the bathroom sink. No hand hygiene was observed before or after the catheter care was performed.</p> <p>During an interview with LPN #9 on 4/6/2016 at 8:10 a.m., she indicated she washed her hands before and after</p>	F 0441	<p>F 441</p> <p>There were no residents affected by the alleged deficient practices, including Residents #2, 29, & 48 but all residents have the potential to be affected. LPN #9 has been re-educated on handwashing during personal care, LPN #9 and the ADON have been educated on infection control practices while handling IV nutrition administration. The Housekeeping Supervisor has been re-educated on linen handling with a special focus on carrying clean linen away from his personal clothing, and the Activity Director has been educated on meal service procedures with a special focus on not touching food with bare hands.</p> <p>Staff have been re-educated on infection control practices including handwashing with a special focus on handwashing before and after personal care, linen handling with a special focus on carrying linen away from the body, food handling with a special focus on not handling food with bare hands, and infection control practices while handling IV nutrition administration. A monitoring tool has been implemented.</p> <p>The Administrator or designee will be responsible for completing observations to ensure infection control practices are being maintained. These observations will occur on scheduled</p>	04/15/2016

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	<p>catheter care.</p> <p>A current policy titled "STEPS, INITIAL AND FINAL- PROVISION OF CARE" was dated 10/2014 and provided by the Director of Nursing (DON) on 4/4/2016 at 10:26 a.m., indicated "Purpose: To provide resident with care in a manner that ensures...infection control....Policy: Nursing personnel are expected to begin care provision with the initial steps and end with the final steps as appropriate to the resident situation, and care to be provided. Procedure: INITIAL STEPS: ...8. Wash Hands....FINAL STEPS: 1. Remove gloves, if applicable, and wash your hands...."</p> <p>2. During an observation of the House Keeping Supervisor on 3/30/2016 at 2:07 p.m., he carried clean bed linens against his clothing into room 104.</p> <p>During an observation of the House Keeping Supervisor on 4/1/2016 at 9:12 a.m., he carried clean blankets against his clothing into room 116.</p> <p>During an interview with the House Keeping Supervisor on 4/4/2016 at 2:20 p.m., he indicated clean laundry should be carried out and away from the body to prevent germs from getting on them.</p>		<p>work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated</p>	

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	<p>A policy titled "Linen Handling" dated 12/2015 was provided by the DON on 4/4/2016 at 2:54 p.m. indicated the following "Policy: The facility shall handle linen in a manner to prevent the spread of infection....Procedure: ...2. Linen will not be carried against the body...."</p> <p>3. During a meal observation on 3/30/2016 at 11:35 a.m., the Activity Director (AD) approached Resident #2 who was sitting at the dining room table in his Broda chair. The AD removed a piece of bread from the plastic covering, held it with her bare hand and proceeded to butter the bread with a plastic knife. The AD picked up a straw, removed the paper from the drinking end of the straw, touched the drinking end of the straw with her bare hands and placed it into a drink for Resident #2. Resident #2 then drank from the straw and ate the buttered bread.</p> <p>During a meal observation on 4/1/2016 at 11:27 a.m., the AD approached Resident #29 as she sat at the dining table. The AD placed her hand on a tortilla on Resident #29's plate and added toppings to it. She then picked up the tortilla and folded the ends and placed it back on the resident's plate. The AD pulled a straw out of the wrapper by the drinking end,</p>			

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	<p>placed it into a drink for Resident #2 and offered the drink to Resident #2.</p> <p>During an interview with the Activity Director on 4/4/2016 at 1:13 p.m., she indicated she never received any training on how to assist a resident in the dining room.</p> <p>A current policy titled "Glove use & Meal Service" was dated 11/2014 and provided by the Director of Nursing on 4/4/2016 at 2:54 p.m., and indicated the following: "Policy: In an effort to protect food products from contamination, all products should be served using utensils...Procedure: ...4. Employees may not touch ready to eat foods with bare hand, gloves must be worn"</p> <p>4. During a medication administration observation, accompanied by the ADON and LPN #9, beginning on 4/5/16 at 9:36 a.m., the following was observed:</p> <p>After washing her hands for 9 seconds and donning gloves, LPN #9 hung a bag of prepared Total Parental Nutrition (TPN, an intravenous feeding solution) for Resident #48 on an IV pole. She then pulled the port cover from the bag and spiked the bag with the administration tubing. The injection port came loose</p>			

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	<p>from the bag, causing liquid formula to drip from the bag and onto LPN #9's left hand. LPN #9 replaced the port plug into the bag with her right hand, which was holding the far end of the administration tubing. LPN #9 removed her gloves, pulled the room curtain back to reach for another pair of gloves, and replaced her gloves. She continued to hold the tubing in her hands throughout.</p> <p>LPN #9 then set the tubing into the IV pump chamber and closed the door. She removed the cap from the end of the tubing. While holding the end of the tubing in her right hand, she began pushing the programming buttons on the pump with her left hand, with her face near the pump. The end of the tubing touched her gloved forefinger on her right hand. LPN #9 moved the tubing to her left hand and began pressing the pump buttons with her right hand. She changed hands two more times. While holding the administration tubing in her left hand, LPN #9 moved the room curtain with her left hand, and pulled two gloves from the wall dispenser. She laid them on the bedside table. She opened an alcohol swab and wiped the end of the tubing with the swab for 3 seconds. While holding the tubing in her left hand, she changed her right glove and wiped the tubing end again with the same</p>			

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	<p>alcohol swab for one second. She indicated she wished she had the cap for the tubing so she could put it down. The ADON entered the bathroom and washed her hands for five seconds, and applied a glove to her right hand, holding the tubing LPN #9 extended to her. LPN #9 indicated she felt like maybe she should change gloves again.</p> <p>LPN #9 wiped the PICC line (a central venous device inserted into the arm) port twice with an alcohol swab and flushed the line with a 10 milliliter syringe. The ADON then handed LPN #9 the administration tubing and LPN #9 inserted it into the port on the PICC line.</p> <p>On 4/5/16 at 10:44 a.m., LPN #9 indicated PICC lines were not uncommon to the facility, however she could not indicate any special training or inservicing she had received on caring for them. She indicated administering TPN was uncommon, but not managing PICC lines.</p> <p>On 4/5/16 at 10:55 a.m., LPN #9 indicated she thought there may be a certain amount of time required to clean a port for a PICC line, but she was not sure how long it was.</p> <p>On 4/5/16 at 11:05 a.m., the DON</p>			

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	<p>indicated there were no specific facility policy on the care of PICC lines.</p> <p>On 4/5/16 at 1:14 p.m., the DON indicated the PICC line should be handled with aseptic technique. She further indicated LPN #9 had informed her she had scrubbed the port prior to administering the TPN.</p> <p>Review of Resident #48's hospital discharge instructions, dated 3/31/16, indicated standardized PICC care was to be provided by the nursing facility.</p> <p>Review of an undated policy titled, "IV Push Therapy", provided by the ADON on 4/5/16 at 10:39 a.m., indicated the following: "...Aseptic technique must be followed during the entire procedure to prevent complications...."</p> <p>3.1-19(g)(2) 3.1-18(l)</p>			