

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F000000	<p>This visit was for the PSR (Post Survey Revisit) to the Investigation of Complaints IN00142493, IN00142570, and IN00142795.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00145475 and IN00145829.</p> <p>Complaint IN00142493- Not corrected.</p> <p>Complaint IN00142570- Not corrected</p> <p>Complaint IN00142795- Not corrected</p> <p>Survey dates: March 10, 11, 12, & 13, 2014</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Survey team: Janet Adams, RN, TC Caityn Doyle, RN March 11, 12, & 13, 2014 Heather Hite, RN March 10, 11, & 12, 2014 Julie Fergueson, RN March 11, 12, & 13, 2014 Jennifer Redlin, RN March 12, 2014</p> <p>Census bed type: SNF/NF: 118 Total: 118</p> <p>Census payor type: Medicare: 26</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 the requirements established by State and Federal law. Whispering Pines requests that this Plan of Correction be considered the facility's Allegation of Compliance. Compliance is effective April 12, 2014.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000157 SS=D	<p>Medicaid: 67 Other: 25 Total: 118</p> <p>Sample: 21</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 21, 2014, by Janelyn Kulik, RN. 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>						

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Physician was notified of changes in respiratory secretions and an alteration in skin integrity for 2 residents in the sample of 21. (Residents #L and #S)</p> <p>Findings include:</p> <p>1. The record for Resident #S was reviewed on 3/12/14 at 10:15 a.m. The resident's diagnoses included, but were not limited to, dementia, insomnia, depression, and psychosis secondary to dementia.</p> <p>The 2/24/14 Minimal Data Set (MDS) Annual Assessment indicated resident's cognitive patterns were severely impaired. The assessment also indicated the resident required limited assistance of one staff member for dressing and personal hygiene. The assessment indicated the resident was totally dependent on staff for bathing.</p> <p>Review of the 2/2014 Skin Shower Sheets indicated the resident received a shower during the day shift on 2/28/14. The body diagram on the sheet indicated a cut was noted in the resident's right armpit area. The shower sheet was completed by QMA #2. The shower sheet was not signed by a Nurse.</p> <p>The 2/2014 and 3/2014 Nursing Progress</p>	F000157	<p>F157 Notify of Changes (Injury/Decline/RoomChanges, etc. RESIDENTS FOUND TOHAVE BEEN AFFECTED:</p> <p>The staff of the facility makes every effort to ensure that the facility immediately informs the resident, consults with the resident's physician, and the residents legal representative or an interesting family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention or any significant change in the residents physical, mental or psychosocial status. Also when a decision is made to transfer or discharge the resident from the facility or when there is a change in room or roommate assignment, or a change in resident's rights. The facility will also record and periodically update any new family pertinent information and place on the face sheet. Resident #S & #L's physician /resident/family/POA have been notified of changes in resident condition.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED:</p> <p>An audit of all residents change in condition status as been conducted</p>	04/12/2014

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	<p>Notes were reviewed. There were no entries made on 2/28/14, 3/1/14, or 3/2/14. An entry was made on 3/3/14 at 2:42 a.m. This entry was noted as "recorded as late entry on 3/3/2014 at 02:46 AM." This entry indicated the resident's family member complained that the resident had not received her shower and "her hair stinks." The CNA and the Nurse apologized and the resident was given a shower. The entry also indicated a cut was noted in the resident's right armpit area. The entry also indicated the resident's family member was present in the shower at this time. The entry did not indicate the Physician had been notified of the cut in the right armpit area.</p> <p>Review of the 3/2014 Treatment Administration Record indicated there was a Physician's order written on 3/1/14 to cleanse the right armpit skin tear with normal saline, apply Bacitracin (an antibiotic ointment) once a day and leave the area open to air. The Treatment Record indicated the above treatment was initiated on 3/1/14.</p> <p>When interviewed on 3/13/14 at 1:00 p.m., QMA #2 indicated she had given the resident a shower on 2/28/14 early in morning. The QMA indicated the resident's family stated to her that the resident had not received her showers. The QMA indicated she then gave the resident a shower and this was when she observed the area to the resident's right armpit. The QMA indicated she informed RN#3 of the area and the RN came and observed the area as she was leaving from the unit after working the night shift.</p> <p>When interviewed on 3/13/14 at 3:00 p.m., the Interim Director of Nursing indicated she had spoken with the RN#3 who made the</p>		<p>to ensure proper notification was completed and documented to include resident/family/POA/physician.</p> <p>SYSTEMIC MEASURES/CORRECTIVE ACTION: The staff has been in-serviced ensuring that immediate notification to resident/family/POA/physician is completed if an injury change in condition transfer or discharge of resident from the facility, or change in room or roommate assignment is completed per facility policy and documented in the resident's clinical record.</p> <p>QUALITY ASSURANCE/MONITORING : The Director of Nursing or designee will audit the resident record documentation three times per week for two months, then two times per week for two months, then weekly for two months with results being forwarded to the QA Committee. If compliance is achieved for two consecutive months, the QA Committee will determine if further auditing is warranted.</p> <p>DATE OF COMPLETION: April 12, 2014</p>	

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	<p>3/3/14 late entry. The Nurse indicated she observed the above area to the resident's right armpit on the morning of 2/28/14 and did not notify the Physician of the area until 3/1/14. The Interim Director of Nursing indicated the resident's Physician should have been notified of the area on 2/28/14 when staff first observed the area during the resident's shower.</p> <p>2. On 03/11/14 at 9:50 a.m., Resident # L, was observed lying on his back in bed. The resident had an oxygen mask covering the stoma(opening in the trachea for breathing). A suction canister was observed at the bedside.</p> <p>The record for Resident #L was reviewed on 03/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), peg tube (tube in stomach for nutrition), history of tracheotomy(opening in throat to breath), and traumatic brain injury.</p> <p>Physician's Orders, originally dated 09/06/13, included for staff to provide Stoma(opening in throat) care each shift and PRN (as needed), suction stoma each shift and PRN and change suction canister daily on the 11:00 p.m.-7 a.m. shift.</p> <p>A care plan dated 11/12/13 indicated the resident was at risk for aspiration due to increased secretions. The care plan indicated the resident had a Tracheotomy Stoma and received tube feedings. The care plan goal was to have no signs and symptoms of aspiration noted. The interventions included, but were not limited to, monitor for signs and symptoms of aspiration., provide Nebulizer treatments as</p>			

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	<p>ordered, notify the Physician as needed, NPO (Nothing By Mouth), tube feedings as ordered, O2 (oxygen) as ordered per trach mask, suction per MD orders, and trach care per facility policy.</p> <p>The resident's Quarterly MDS (Minimal Data Set) Assessment dated 12/28/13, indicated the following: Resident was rarely/never understood, totally dependent for transfers, eating, and bathing with 2 plus person assist, dressing and bed motility extensive assistance with 2 plus person assist. Always incontinent of bowel and bladder</p> <p>Review of 02/14 MAR (Medication Administration Record), indicated the resident received Erythromycin (an antibiotic) on 02/12/14 for 10 days for a diagnosis of an upper respiratory infection.</p> <p>Review of 3/14 Nursing Progress notes were reviewed. The following entries were noted: 03/07/13 at 09:56 p.m., " Res (Resident) noted to have thin light yellow secretions from patent trach stoma...."</p> <p>03/09/14 at 07:20 p.m., Resident alert...Suctioned thick, green secretions</p> <p>03/10/14 at 12:00 p.m., Resident alert..Suctioned thick, green secretions</p> <p>03/10/14 at 7:40 p.m., Resident alert...Suctioned thick, green secretions...."</p> <p>There was no documentation of resident's Physician being notified of the onset of the green secretions in the above entries.</p> <p>During an interview on 03/11/14 at 2:34 p.m., the Interim DoN (Director of Nursing)</p>			

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F000166 SS=D	<p>indicated the Physician should be notified with any change in condition. The DoN indicated the Physician should have been notified when the sputum changed color.</p> <p>On 03/11/14 at 2:09 p.m., the Interim DoN provided the policy titled "PHYSICIAN NOTIFICATION FOR CHANGE IN CONDITION POLICY." The Interim DoN indicated this document was current. The policy indicated the Physician was to be notified of changes in the resident's physical or mental condition status immediately. The policy also indicated the notification of the Physician and families/legal representatives were to be documented in the resident's clinical record.</p> <p>This Federal tag relates to Complaint IN00142493.</p> <p>This deficiency was cited on January 29, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-5(a)(2) 3.1-5(a)(3) 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on observation, record review and interview, the facility failed to ensure staff members followed the grievance protocol related to not reporting and completing Grievance Forms when residents and family</p>	F000166	<p>F166 Right to Prompt Efforts to ResolveGrievances: RESIDENTS FOUND TOHAVE BEEN AFFECTED: The staff of thefacility makes every effort to ensure that staff members</p>	

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	<p>members voiced concerns about missing coins and lack of providing personal hygiene care for 2 residents in the sample of 21. (Residents #R and #S)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 3/10/14 at 7:50 p.m. with RN #1, Resident #R was observed sitting in a wheelchair in the hallway near her room. The resident was talking with another resident who was sitting by her. The resident stated she had \$5.00 in quarters from Bingo and someone had taken her quarters.</p> <p>The record for Resident #R was reviewed on 3/12/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, left hip fracture, anemia, and high blood pressure.</p> <p>The 2/11/14 Minimum Data Set (MDS) Quarterly Assesment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). This score indicated the resident's cognitive patterns were moderately impaired. The MDS also indicated the resident did not have any behaviors.</p> <p>Review of the 2/26/14 and 3/3/14 Physician Progress Notes indicated the resident was alert and orientated x 3.</p> <p>A Grievance Report Form was reviewed on 3/12/14. The Grievance Report Form was dated 3/11/14. The form indicated the resident reported she had a jar of about \$5 dollars in change that disappeared. The form indicated the incident occurred on 3/10/14 at 4:00 p.m.</p>		<p>follow the grievance protocol related to, not reporting and completing Grievance Forms when residents and family members voiced concerns about missing items and family members voiced concerns regarding resident care. Resident #R, & #S have had their grievances addressed and grievance forms completed and documented in the resident record.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED:</p> <p>An audit of all resident's grievance forms was conducted to ensure that follow up and documentation of resolution was completed.</p> <p>SYSTEMIC MEASURES/CORRECTIVE ACTION:</p> <p>The staff has been in-serviced on ensuring that all grievances are entered on a Grievance Form and follow ups per facility policy.</p> <p>QUALITY ASSURANCE/MONITORING :</p> <p>The Director of Nursing or designee will audit the grievance log three times weekly for two months, then two times per week for two months and weekly for two months, with results being forwarded to the QA Committee. If compliance is achieved for two months consecutively, the QA Committee will determine if further auditing is warranted.</p> <p>DATE OF COMPLETION: April 12, 2014</p>				

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	<p>When interviewed during Orientation Tour on 3/10/14 at 7:47 p.m., RN #1 indicated Resident #R had been talking about missing quarters earlier in the shift. The RN indicated she looked in the resident's room and did not find them. The RN indicated the resident seemed to be having some confusion.</p> <p>When interviewed on 3/11/14 at 12:20 p.m., the facility Administrator indicated he was not aware of Resident #R reporting any missing money.</p> <p>When interviewed on 3/11/14 at 12:34 p.m., the Activity Director indicated a Nurse approached her a few minutes ago and informed her about the missing money. The Activity Director indicated the Nurse did not tell her when the resident first reported the missing money. The Activity Director indicated the Nurse should have filled out a grievance form when the resident first reported she was missing money.</p> <p>2. The record for Resident #S was reviewed on 3/12/14 at 10:15 a.m. The resident was admitted to the facility on 12/23/11. The resident's diagnoses included, but were not limited to, dementia, insomnia, depression, and psychosis secondary to dementia.</p> <p>The 2/24/14 Minimal Data Set (MDS) Annual Assessment indicated resident's cognitive patterns were severely impaired. The assessment also indicated the resident required limited assistance of one staff member for dressing and personal hygiene. The assessment indicated the resident was totally dependent on staff for bathing.</p> <p>Review of the 2/2014 Skin Shower Sheets indicated the resident received a shower</p>			

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F000282 SS=D	<p>during the day shift on 2/28/14. There were no other 2/2014 Shower Sheets available.</p> <p>The 2/2014 and 3/2014 Nursing Progress Notes were reviewed. There were no entries made on 2/28/14, 3/1/14, or 3/2/14. An entry was made on 3/3/14 at 2:42 a.m. This entry was noted as "recorded as late entry on 3/3/2014 at 02:46 AM." This entry indicated the resident's family member complained that the resident had not received her shower and "her hair stinks." The CNA and the Nurse apologized and the resident was given a shower.</p> <p>When interviewed on 3/13/14 at 1:30 p.m., the Interim Director of Nursing indicated there should have been a grievance form filled out on 2/28/14 when the family voiced the concern.</p> <p>This Federal tag relates to Complaints IN0014250 and IN00142795.</p> <p>This deficiency was cited on January 29, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-7(b) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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, record review, and interview, the facility failed to ensure the resident's plan of care was followed related</p>	F000282	F 282 Service By Qualified Persons/Per Care Plan RESIDENTS FOUND TOHAVE BEEN AFFECTED:	

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	<p>wedge pillow and neck supports not in place for 2 residents in the sample of 21. (Residents #F and #Y)</p> <p>Findings include:</p> <p>1. On 3/11/14 at 8:00 a.m., Resident #F was observed sitting in a wheelchair. There was no abductor cushion between the resident's thighs.</p> <p>Continuous observation of the resident on 3/11/14 from 9:05 a.m. though 11:30 a.m. indicated the resident was observed sitting in a wheelchair. There was no abductor pillow between the resident's thighs during this time.</p> <p>Continuous observation of the resident on 3/11/14 from 1:05 p.m. through 1:20 p.m. indicated the resident was observed sitting in a wheelchair. There was no abductor pillow between the resident's thighs during this time.</p> <p>On 3/11/14 at 1:25, CNA #4 and CNA #8 were observed transferring the resident into bed. The resident did not have any abductor pillow in place at this time.</p> <p>The record for Resident #F was reviewed on 3/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, arthritis, osteoporosis dementia, Parkinson's, dysphasia (difficulty swallowing), and depression.</p> <p>Review of the 2/26/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident's BIMS(Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive pattern was</p>		<p>The staff of the facility makes every effort to ensure the resident plan of care is followed. Resident #F & #Y care plans has been updated to ensure the plan of care is being followed.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED: All residents have the potential to be affected. All resident care plan have been reviewed with changes made as necessary. The staff has been in-serviced on ensuring that all resident's care plans are followed as written.</p> <p>SYSTEMIC MEASURES / CORRECTIVE ACTION: The staff has been in-serviced on ensuring that all resident care plans are followed as written. Rehab has evaluated Resident F for repositioning. Care plan interventions have been added to the CNA assignments sheets and will be up-dated as the needs of the resident warrant. This will be completed by the MDS Nurse.</p> <p>QUALITY ASSURANCE / MONITORING : The Director of Nursing and/or designee will audit the care plan to ensure that are being updated with new interventions and those interventions reflected on the CNA work sheet, three times per week for two months, then two times per week for two months and then weekly for two months. The results will be being forwarded to</p>	

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	<p>moderately impaired. The assessment also indicated the resident required extensive assistance of two or more staff members for transfers. The assessment also indicated the resident required extensive assistance of one staff member for dressing and eating, and was totally dependent on one staff member for toilet use and personal hygiene.</p> <p>The CNA Sheets for the resident's unit were reviewed. The Sheets were "revised" on 2/28/14. The Sheets indicated Resident #F required assistance of (2) staff members for transfers and an abductor pillow was to be placed between the resident's thighs when she was up in the wheelchair.</p> <p>When interviewed on 3/11/14 at 11:33 a.m., CNA #8 indicated he was not assigned to care for Resident #F today but had cared for the resident on other days. The CNA indicated the resident was to have a "wedge" pillow between her legs. The CNA indicated he noticed the pillow was not in place when he just transferred the resident into bed. The CNA indicated he looked in her room at this time and did not find the pillow. The CNA indicated the resident was up in the wheelchair at the start of the Day shift at 6:00 a.m.</p> <p>2. On 3/13/14 at 4:35 a.m., CNA #9 was observed bringing Resident #Y down the hall into the Linden Unit Dining Room. The CNA placed the resident up to a table in the Dining Room. The resident was seated in a high back wheel chair. The back of the resident's head was not resting against the back of the wheelchair. There was approximately 5 inches between the back of the resident's head and the back of the wheelchair. There</p>		<p>the QA Committee. If compliance is achieved for two consecutivemonths, the QA Committee will determine if further auditing is warranted.</p> <p>DATE OF COMPLETION: April 12, 2014</p>	

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	<p>was a black cushion with a curved out area, which would be for the back of the resident's neck to rest against, attached to the back of her wheelchair. This cushion was flipped over the back of the wheelchair instead of next to the resident's neck.</p> <p>Continued observation of the resident on 3/13/14 from 4:45 a.m. until 7:15 a.m. indicated the resident remained up in the same wheelchair at the table in the Dining Room. The neck cushion remained flipped over the back of the wheelchair through the above times.</p> <p>The record for Resident #Y was reviewed on 3/14/14 at 6:32 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, seizure disorder, and high blood pressure.</p> <p>Review of the 2/19/14 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assistance of two or more staff for bed mobility and transfers.</p> <p>When interviewed on 3/14/14 at 7:50 a.m., the facility Administrator indicated the wedge should have been in place.</p> <p>This Federal tag relates to Complaints IN00142570 and IN00142795.</p> <p>This deficiency was cited on January 29, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to provide interventions for resident's complaints of pain which resulted in the resident having continued pain for 1 of 21 sampled residents. (Resident #F)</p> <p>The facility also failed to ensure an alteration in skin integrity was treated timely for 1 of 21 sampled residents. (Resident #S)</p> <p>Findings include:</p> <p>1. On 3/11/14 at 8:00 a.m., Resident #F was observed sitting in a wheelchair at a table in the Pines North unit day/dining room for the breakfast meal. The resident had not received her breakfast tray at this time. The resident's head/neck were leaning to the left. There were no pillows or cushions in place to support the resident's neck. Continuous observations of the resident on 3/11/14 from 9:05 a.m. through 11:30 a.m. were as follows:</p> <p>At 9:05 a.m., the resident was observed seated in the same area. The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck.</p>	F000309	<p>F 309 Provide Care/Services For The Highest WellBeing RESIDENTS FOUND TOHAVE BEEN AFFECTED:</p> <p>The staff of the facility makes every effort to ensure the facility provides interventions forresident's complaints of pain which resulted in the resident having continuedpain. Resident #F had a pain assessmentcompleted and care plan interventions updated. The staff of the facility also makes every effort to ensure anyalterations in skin integrity is treated timely. Resident #S received a complete weekly skinand body check and any change in skin or condition is immediately reported toresident/family/POA/physician. OTHER RESIDENTSPOTENTIALLY AFFECTED:</p> <p>All residents havehad a skin assessment completed. Twiceweekly shower sheets will be reviewed and signed off by nurse on duty. If any problems are found, the nurse will askthe physician for a</p>	04/12/2014

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	<p>At 9:10 a.m., CNA #4 approached the resident and pushed her in the wheelchair from the Pines North Unit day/dining room down the hall to the Pines South unit. The CNA placed the resident in the TV lounge area directly across from the Nursing Station. The CNA placed the resident's wheelchair directly in front of the TV. The TV was not on. The residents head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck.</p> <p>At 9:50 a.m., Housekeeping staff entered the area and mopped the floor in the lounge. Housekeeping staff mopped around the resident's wheelchair. The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck.</p> <p>At 9:57 a.m., CNA #4 approached the resident and pushed her down to the end of the hall where QMA #1 was present next to the Medication Cart. The CNA then pushed the resident back down the hall into the shower room. The QMA followed into the shower room holding the resident's medications. The CNA left the shower room. QMA #1 had the resident's medication crushed in a cup of applesauce. The QMA attempted to give the resident the pills in the applesauce and the resident did not take them. The QMA asked the resident if she was in pain and the resident nodded her head slightly and mumbled something not understandable. The QMA asked the resident where her pain was and the resident lifted her hand and pointed to her abdomen and then to the right side of her neck. The resident's head/neck remained tilted to the left. No cushions or pillows were in place</p>		<p>treatment order.</p> <p>An audit of each resident's pain assessment has been completed to ensure that it is completely timely upon admission, quarterly and with each new incidence of resident complaints of pain.</p> <p>SYSTEMIC MEASURES/CORRECTIVE ACTION:</p> <p>The staff has been in-serviced on facility policy and procedure for pain management and assessments. The staff has also been in-serviced on the facility policy and procedure on "Skin Condition & Pressure Ulcer Assessment Policy". Resident F has been evaluated by Physical Therapy for positioning.</p> <p>QUALITY ASSURANCE/MONITORING</p> <p>The Director of Nursing or designee will audit the Pain Assessments and shower /treatment sheets of each resident three times weekly for two months, then two times weekly for two months and weekly for twelve weeks. The results will be forwarded to the QA Committee. If compliance is achieved for two consecutive months, the QA Committee will determine if further auditing is warranted.</p> <p>DATE OF COMPLETION: April 12, 2014</p>	

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	<p>around the resident's neck. The QMA then applied an Exelon topical patch (a medicated patch to treat dementia) to the resident's upper right back area. The QMA then took the resident out of the shower room into the hallway and reported to RN #1 that the resident was having neck pain and stomach pain and was not given her pills but she had just applied the resident's "pain patch." The residents head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck.</p> <p>At 10:10 a.m., The resident remained up in the wheelchair in the above area with RN #1, CNA #4, and QMA#1 present. The RN placed a rolled up towel to the area between the top of the resident's left clavicle area so her head would rest on the towel for support.</p> <p>At 10:16 a.m., CNA #4 pushed the resident back down to the Pines South unit TV lounge area.</p> <p>At 10:20 a.m., CNA #7 entered the TV lounge area and approached the resident. The resident reached out to hold the CNA's hand and would not let it go for several seconds. The CNA talked to the resident and asked the resident to let go of her hand. The residents head/neck remained tilted to the left.</p> <p>At 10:22 a.m., RN #1 entered the TV lounge area and approached the resident. The resident took a hold of the nurses hand. The RN than asked the resident if she wanted a glass of water and then got a glass of water for her.</p> <p>At 10:40 a.m., The resident remained in the TV lounge area. The resident's head/neck</p>			

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	<p>remained tilted to the left. The rolled towel which was between the resident's clavicle and her head rolled off onto the floor next to her wheelchair.</p> <p>At 10:45 a.m. The Activity Director entered the lounge area and walked towards the resident's wheelchair and picked up the towel from the floor. The Activity Director placed the towel on the counter at this time. The resident's head/neck remained tilted to the left.</p> <p>At 10:55 a.m., The Activity Director took the resident from the lounge area on Pines South to the Living Room area between the Pines North & South Units where activities were going on in the Living Room area. The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck.</p> <p>At 11:10 a.m., The Activity Director took the resident from the Living Room area back down to the Pines South Unit and left the resident by the Medication Cart in the hallway. QMA #1 approached the resident and asked the resident if she wanted to stay up and eat lunch. The QMA then asked the resident if she wanted something for pain and the resident said yes. The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck.</p> <p>At 11:15 a.m., RN #1 was standing by the resident at the Medication Cart and the QMA told the nurse the resident wanted to lay down. The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck. The towel that RN#1 had earlier placed for the</p>			

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	<p>resident's neck was not in place.</p> <p>At 11:18 a.m., QMA #1 approached the resident and instructed the resident she was going to give her " Tylenol (a medication for pain) for your neck." The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck. The towel that RN#1 had earlier placed for the resident's neck was not in place.</p> <p>At 11:25 a.m., QMA #1 took the resident down the hall to the Pines North Unit. The QMA pushed the resident's wheelchair up to a table in the Day/Dining area. The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck. The towel that RN#1 had earlier placed for the resident's neck was not in place.</p> <p>The resident was next observed on 3/11/14 at 1:05 p.m. The resident was observed still at the table in the Pines North day/dining area. The resident's head/neck remained tilted to the left. No cushions or pillows were in place around the resident's neck. The towel that RN#1 had earlier placed for the resident's neck was not in place.</p> <p>On 3/11/14 at 1:25 p.m., CNA #4 and CNA #8 were observed transferring Resident #F from the wheelchair into her bed. The CNA's applied a gait belt around the resident's waist and lifted her into the bed. A blue moon shaped padded travel neck pillow was observed on the resident's bed at this time.</p> <p>The record for Resident #F was reviewed on 3/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to,</p>			

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	<p>arthritis,osteoporosis dementia, Parkinson's, dysphagia (difficulty swallowing) and depression.</p> <p>Review of the 2/26/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident BIMS (Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive pattern were moderately impaired. The assessment also indicated the resident required extensive assistance of two or more staff members for transfers. The assessment also indicated the resident required extensive assistance of one staff member for dressing and eating and was totally dependent on one staff member for toilet use and personal hygiene.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 9/23/13 indicated the resident had the potential for pain related to diagnoses of Parkinson's Disease. The care plan goal date was 4/1/2014. Care plan approaches included for staff to administer medications as ordered, monitor and record any complaints of pain including the location, duration and alleviating factors, and to monitor any non verbal signs of pain.</p> <p>The unit CNA sheets for the unit the resident resided on were reviewed. The CNA sheets indicated the resident was incontinent and required assistance of staff for transfers. The CNA sheets also indicated the resident was to be turned every two hours.</p> <p>Review of the 3/2014 MAR (Medication Administration Record) indicated there were Physician orders for the resident to have an Exelon (a medication for dementia) 9.5 milligram patch topically applied daily at 8:00</p>			

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	<p>a.m. There were also orders for the resident to receive Acetaminophen 500 milligrams every four hours as needed. The acetaminophen was signed out at given on 3/11/14 at 11:10 a.m. for complaints of right neck pain at a severity level of #5 (on scale of 1-10). The Medication Administration Record indicated there were no Physician order for any type of topical patch for the treatment of pain.</p> <p>The Nursing 2014 Drug Handbook indicated indicates for the use of Exenon patches included treatment of mild to moderate dementia and mild to moderate dementia associated with Parkinson Disease. The 2014 Drug Handbook did not indicate Exelon patches were to be used for the treatment of pain.</p> <p>When interviewed on 3/11/14 at 1:33 p.m., CNA #4 indicated he was not assigned to care for the resident this day but does help care for the resident when needed. The CNA indicated he ha cared for the resident at other times before. The CNA indicated the travel neck pillow in the resident's room was hers. CNA #4 indicated the resident did use the pillow when she had pain in the neck and it helps her.</p> <p>When interviewed on 3/11/14 at 4:45 p.m., the facility Administrator indicated the resident should have been repositioned through the day if she was left up in the her wheelchair and treated for pain.</p> <p>2. The record for Resident #S was reviewed on 3/12/14 at 10:15 a.m. The resident was admitted to the facility on 12/23/11. The resident's diagnoses included, but were not limited to, dementia, insomnia, depression,</p>			

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	<p>and psychosis secondary to dementia.</p> <p>The 2/24/14 Minimal Data Set (MDS) Annual Assessment indicated resident's cognitive patterns were severely impaired. The assessment also indicated the resident required limited assistance of one staff member for dressing and personal hygiene. The assessment indicated the resident was totally dependent on staff for bathing.</p> <p>Review of the 2/2014 Skin Shower Sheets indicated the resident received a shower during the day shift on 2/28/14. The body diagram on the sheet indicated a cut was noted in the resident's right armpit area. The shower sheet was completed by QMA #2. The shower sheet was not signed by a Nurse.</p> <p>The 2/2014 and 3/2014 Nursing Progress Notes were reviewed. There were no entries made on 2/28/14, 3/1/14, or 3/2/14. An entry was made on 3/3/14 at 2:42 a.m. This entry was noted as "recorded as late entry on 3/3/2014 at 02:46 AM." This entry indicated the resident's family member complained that the resident had not received her shower and "her hair stinks." The CNA and the Nurse apologized and the resident was given a shower. The entry also indicated a cut was noted in the resident's right armpit area. The entry also indicated the resident's family member was present in the shower at this time. The entry did not indicate the Physician had been notified of the cut in the right armpit area.</p> <p>There were no skin or wound assessment forms in the resident's record. There was no further documentation of any assessment of the characteristic or measurements of the cut</p>			

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	<p>noted on the resident's armpit completed in February or March.</p> <p>Review of the 3/2014 Treatment Administration Record indicated there was a Physician's order written on 3/1/14 to cleanse the right armpit skin tear with normal saline, apply Bacitracin (an antibiotic ointment) once a day and leave the area open to air. The Treatment Record indicated the above treatment was initiated on 3/1/14.</p> <p>When interviewed on 3/13/14 at 1:00 p.m., QMA #2 indicated she had given the resident a shower on 2/28/14 early in morning. The QMA indicated the resident;s family stated to her that the resident had not received her showers. The QMA indicated she then gave the resident a shower and this was when she observed the area to the resident's right armpit. The QMA indicated she informed RN#3 of the area and the RN came and observed the area as she was leaving from the unit after working the night shift.</p> <p>When interviewed on 3/13/14 at 3:45 p.m., the Interim Director of Nursing indicated she had spoken with the RN#3 who made the 3/3/14 late entry. The Nurse indicated she observed the above area to the resident's right armpit on the morning of 2/28/14 and did not notify the Physician of the area until 3/1/14. The Interim Director of Nursing indicated the resident's Physician should have been notified of the area on 2/28/14 when staff first observed the area during the resident's shower. The Interim Director of Nursing also indicated a wound sheet should have been initiated for the area on 2/28/14 which would include an assessment and description of the area involved such as size and color.</p>			

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F000312 SS=E	<p>The "Skin Condition and Pressure Ulcer Assessment Policy" was reviewed on 3/12/14 at 4:30 p.m. There was no date on the policy. The Interim Director of Nursing provided the policy and indicated the policy was current. The policy indicated Nursing staff were to complete a skin and body check for each resident at least weekly. The assessments were to include pressure ulcers, other ulcers and skin problems and the findings were to be reported on skin forms.</p> <p>This Federal tag relates to Complaint IN00142493.</p> <p>This deficiency was cited on January 29, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-37(a) 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 observation, record review, and interview, the facility failed to provide the necessary assistance with feeding for (4) residents in the sample of 21 who were dependent on staff for feeding assistance. (Residents #E, #F, #K, and #S) The facility also failed to provide the necessary assistance with incontinence care and repositioning for (7) residents in sample</p>	F000312	F 312 ADL Care Provided For Department Residents RESIDENTS FOUND TOHAVE BEEN AFFECTED: The staff of thefacility makes every effort to ensure they provide the necessary assistancewith feeding residents who are dependent on staff for feeding assistance. The staff also makes every effort to	

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	<p>of 21 who were dependent on staff for incontinence care and repositioning. (Residents #D, #F, #P, #U, #Y, and #Z) The facility also failed to provide the necessary assistance with bathing for (2) residents in the sample of 21 which were dependent on staff for showering. (Residents #D, #S & #B)</p> <p>Findings include:</p> <p>1. The Evening meal service was observed in the Pines North Unit day/dining room across from the Nursing Station on 3/10/14 at 6:13 p.m. Staff were observed starting to pass meal trays at his time.</p> <p>Resident #F received her meal tray at 6:13 p.m. Staff placed a plate of food on the table in front of the resident. The resident's silverware was wrapped in a white napkin and was not opened. There were no staff members at the table at this time. Resident #F reached for her plate and touched the coleslaw with her fingers. The resident again reached for the plate but did not touch the plate of food. Staff were not at the table feeding at this time. No cueing was provided at this time.</p> <p>At 6:20 p.m., the resident was observed eating the coleslaw from her plate with her finger. The resident's silverware was still not unwrapped. The resident put her finger into the coleslaw and scooped up some of the coleslaw. The coleslaw fell onto the resident's pants before she was able to get it to her mouth. The resident again put her finger in the coleslaw but did not pick any up. No staff intervened to cue or feed the resident at this time. At this time CNA #2 told another CNA to "hand that sandwich to</p>		<p>providethe necessary assistance with incontinence care and repositioning forresidents. Residents identified were #E,#F, #K and #S. Resident's #D, #F, #P,#U, #Y and #Z were identified as needing incontinence care, repositioning andfeeding. Resident's #D, #S, #B wereidentified as needing assistance with bathing. Residents #D, #F, #P, #U, #Y, and #Z all received incontinence care,were repositioned and received feeding assistance. Resident's #D, #S, and #B received assistancewith bathing.</p> <p>OTHER RESIDENTSPOTENTIALLY AFFECTED: An audit of allresidents who need feeding & bathing assistance, incontinence care and repositioninghas been conducted to ensure all residents receiving feeding & bathingassistance, incontinence care and repositioning. New shower sheets have been implemented andthe nurse must reviewed the sheet twice weekly and sign off as shower given andskin reviewed.</p> <p>SYSTEMICMEASURES/CORRE CTIVE ACTION: The staff has beenin-serviced on ensuring that residents receive feeding</p>	

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	<p>her" and the second CNA lifted up the sandwich with a napkin and tried to give it to the resident. The resident was not able to grab the sandwich so the CNA put it down and cut it into smaller pieces. CNA #2 then started feeding the resident. The CNA continued to feed the resident. While she was feeding Resident #F, the CNA got up off her chair and went to window to adjust the window twice and also got up several times to go to another table to cue other residents. The CNA then would return to feed the resident.</p> <p>The record for Resident #F was reviewed on 3/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, arthritis, osteoporosis dementia, Parkinson's, dysphagia (difficulty swallowing,) and depression.</p> <p>Review of the 2/26/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident BIMS (Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive pattern were moderately impaired. The assessment also indicated the resident required extensive assistance of two or more staff members for transfers. The assessment also indicated the resident required extensive assistance of one staff member for dressing and eating and was totally dependent on one staff member for toilet use and personal hygiene.</p> <p>2. The Evening meal service was observed in the Pines North Unit day/dining room across from the Nursing Station on 3/10/14 at 6:13 p.m. Staff were observed starting to pass meal trays at his time.</p> <p>Resident #E was observed seated at table</p>		<p>& bathing assistance, incontinence care and repositioning to maintain good nutrition to prevent weight loss and maintain skin integrity through proper repositioning and skincare. Resident F has been evaluated by Physical Therapy for positioning.</p> <p>QUALITY ASSURANCE/MONITORING: The Director of Nursing or designee will audit the weight logs, shower sheets, turn schedules and wound logs three times per week for two months, then two times per week for two months, then once weekly for twelve weeks with the results being followed to the QA Committee.</p> <p>If compliance is achieved for two consecutive months, The QA Committee will determine if further auditing is warranted.</p> <p>DATE OF COMPLETION: April 12, 2014</p>	

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	<p>next to Resident #F. The resident was served a tray at 6:18 p.m. A staff member placed a plate of food on the table in front of Resident #E. There was silverware wrapped in a white napkin on the table. The resident received a pureed diet. The resident began to put her finger into the serving of pureed meat and the meat dropped onto the table. The resident then continued to move her finger back and forth around the plate at times.</p> <p>At 6:20 p.m., the resident was observed sticking her finger into the meat and bringing her finger back and forth to her mouth with no food on it. The resident was also observed sticking her spoon into a cup of thickened liquid beverage and then would hold the spoon pointing down at the table with the liquid seeping off. The resident was did not bring the spoon to her mouth. At 6:25 p.m. a CNA unwrapped the resident's silverware and gave it to the resident. The resident again placed her fingers on the plate and the CNA then started to assist the resident. CNA #2 then began feeding the resident. CNA #2 several times got up off her chair and went to window to adjust the window twice and also got up several times to go to another table to cue other residents. The CNA then would return to feed the resident more.</p> <p>The record for Resident #E was reviewed on 3/11/14 at 9:29 a.m. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), Alzheimer's Disease, arthritis and depression.</p> <p>The 1/11/14 Minimum Data Set (MDS) Assessment indicated the resident required extensive assistance of one staff member</p>			

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	<p>with eating.</p> <p>A care plan dated 2/11/14 indicated the resident displayed a self-care deficit. Care plan approaches indicated the resident required extensive assistance to complete dependence with eating.</p> <p>3. The Evening meal service was observed in the Pines North Unit day/dining room across from the Nursing Station on 3/10/14 at 6:13 p.m. Staff were observed starting to pass meal trays at his time. Resident #K was served his meal tray at 6:15 p.m. The resident's silverware was wrapped in a white napkin and was not opened by staff at this time. At 6:25 p.m., the resident remained seated at the table with his meal plate on the table. The resident had not touched any of his food. There were two empty glasses on the table. No beverages were poured into the cups.</p> <p>At 6:26 p.m., CNA #2 approached the resident and picked up 1/2 of the resident's sandwich and [paced it in the his left hand. The CNA then left the table and left. The resident then was observed with his left hand resting on the table with the sandwich in this hand. The resident's head was bent down with his mouth on the sandwich. The resident did not appear to be taking bites of the sandwich or chewing anything. The staff did not provide any hand over hand assistance. The resident remained in this position for several minutes. The resident's silverware was not unwrapped. The resident had coleslaw and peaches. He did not touch or eat any of these.</p> <p>At 7:00 p.m., a staff member came into the Dining Room and told Orientating CNA #1 to</p>			

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	<p>feed Resident #K after she finished feeding the resident she was feeding at another table. At 7:05 p.m., this CNA came to Resident #K's table and began to feed the resident his coleslaw and peaches. The resident ate all his coleslaw and peaches when fed by the CNA. The CNA gave the resident a glass of juice which was served to him. The resident drank all the juice the CNA gave him.</p> <p>The record for Resident #K was reviewed on 3/11/14 at 10:41 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, hemiplegia (weakness in one side of the body), and depression.</p> <p>Review of the 2/25/14 Quarterly MDS Assessment indicated the resident was rarely or never understood. The assessment indicated the resident required extensive assistance of one staff person for eating.</p> <p>The resident's current care plans were reviewed. A care plan with a goal date of 5/31/14 indicated the resident was at nutritional risk related to dementia and had been noted to be pocketing food. Care plan interventions were to provide supervision during the resident's meal .</p> <p>A second care plan indicated the resident had a self care deficit and required assistance with daily care. Care plan interventions noted that at times the resident would stop feeding himself and required hand over hand guidance to try again. Staff were also to provide more assistance if needed.</p> <p>4. On 3/13/14 at 4:35 a.m., CNA #9 was observed bringing Resident #Y down the hall into the Linden Unit Dining Room. The CNA</p>			

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	<p>placed the resident up to a table in the Dining Room. There were no other staff member on the unit at this time. The resident remained seated at the table from 4:35 a.m. until 7:26 a.m. CNA #9 did not remove the resident from this area at any time during this period.</p> <p>The record of Resident #Y was reviewed on 3/13/14 at 6:32 a.m. The resident's diagnoses included , but were not limited to, Alzheimer's Disease, seizure disorder, and high blood pressure.</p> <p>Review of the 2/19/14 Minimum Data Set (MDS) Quarterly Assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assistance of two or more staff for bed mobility and transfers. The assessment also indicated the resident required extensive assistance of two or more staff members for toilet use. The assessment also indicated the resident was frequently incontinent of urine and always incontinent of stool.</p> <p>When interview on 3/13/14 at 8:15 a.m., CNA #10 indicated she was working the day shift. The CNA indicated the resident was up in her wheelchair when she came on and she did not toileted or provide incontinence care for the resident so far this shift. The CNA indicated she had been getting the other residents up since the start of her shift.</p> <p>5. On 3/13/14 at 5:05 a.m., CNA #9 was observed transferring Resident #Z from her bed into a wheelchair. The CNA then pushed the resident to the Linden Unit Dining Room. There were no other staff members on the unit at this time. The resident remained seated at the table until 7:26 a.m. CNA #9 did</p>			

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	<p>not remove the resident from this area at any time during this period.</p> <p>The record for Resident #Z was reviewed on 3/13/14 at 11:00 a.m. The resident's diagnoses included, but were not limited to, advanced dementia, Alzheimer's Disease, Parkinson's, muscle weakness, and anxiety.</p> <p>Review of the 2/26/14 Quarterly MDS Assessment indicated the resident was rarely or never understood. The assessment also indicated the resident required extensive assistance of one person for transfers, dressing, personal hygiene and dressing. The assessment indicated the resident was always incontinent of bowel and bladder.</p> <p>When interview on 3/13/14 at 8:15 a.m., CNA #10 indicated she was working the day shift. The CNA indicated the resident was up in her wheelchair when she came on and she did not toilet or provide incontinence care for the resident so far this shift. The CNA indicated she had been getting the other residents up since the start of her shift.</p> <p>6. On 3/13/14 at 4:45 a.m., CNA #9 was observed pushing Resident #U in a wheelchair into the Linden Unit Dining Room. There were no other staff members on the unit at this time. The resident remained seated at the table from 4:35 a.m. until 7:26 a.m. CNA #9 did not remove the resident from this area at any time during this period.</p> <p>The record for Resident #U was reviewed on 3/13/14 at 11:30 a.m. The resident's diagnoses included, but were not limited to, senile dementia, osteoporosis, gastritis, and Alzheimer's Disease.</p>			

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	<p>Review of the 2/13/14 MDS Annual Assessment indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance of two plus staff persons for transfers, toilet use, and personal hygiene. The assessment also indicated the resident was always incontinent of bladder and frequently incontinent of bowel.</p> <p>When interview on 3/13/14 at 8:15 a.m., CNA #10 indicated she was working the day shift. The CNA indicated the resident was up in her wheelchair when she came on and she did not toilet or provide incontinence care for the resident so far this shift. The CNA indicated she had been getting the other residents up since the start of her shift.</p> <p>7. On 3/12/14 at 12:15 p.m., the tray cart for the noon meal arrived in the Linden Unit dining room. Four staff members were passing out trays at this time. At 12:24 p.m. all 11 residents seated in the dining room had been served. Resident #S was observed walking up and down the Linden Unit hallway at this time.</p> <p>At 12:25 p.m. Resident #S walked into the dining room and sat down at her table. Resident #S remained seated at her table from 12:25 p.m. until 12:30 p.m. There were four staff members present in the dining room at this time. There were no attempts by staff to serve Resident #S her tray. At 12:30 p.m. Resident #S got up from her table and left the dining room.</p> <p>At 12:30 p.m., CNA #11 was observed assisting two residents with eating. The Activities Director was assisting two residents</p>			

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	<p>with eating. CNA #12 was assisting 4 residents with eating. At this time the Activities Assistant left the Linden Unit to go look for another staff member to help assist the residents with eating.</p> <p>At 12:44 p.m., the Activities Assistant returned to the Linden Unit and indicated she was unable to find anyone to help assist the residents with eating.</p> <p>From 12:30 p.m. until 12:50 p.m., Resident #S was observed wandering up and down the Linden Unit Hallway. There were no attempts made by staff during this time to direct the resident to the dining room.</p> <p>At 12:50 p.m., CNA #13 entered the Linden Unit Dining room and immediately noticed Resident #S was not in the dining room and had not received her lunch tray. CNA #13 then went to find Resident #S and assisted her to the dining room. Resident #S was served her lunch meal at 12:51 p.m. and CNA #13 assisted her with eating.</p> <p>Resident #S received her meal 25 minutes after the tray cart arrived on the Linden Unit.</p> <p>The record for Resident #S was reviewed on 3/12/14 at 2:00 p.m. The Resident's diagnoses included, but were not limited to, dementia and depressive disorder.</p> <p>The current nutritional care plan indicated Resident #S required assistance with meals and staff should encourage oral intake of foods and fluids.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment, dated 2/24/14, indicated Resident #S required limited assistance with</p>						

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	<p>one person physical assist for eating.</p> <p>Interview with Confidential Staff Member on 3/12/14 at 12:55 p.m., indicated Resident #S was not assisted with eating until 12:50 p.m. because there was not enough staff available to assist all the residents who required assistance with eating. Further interview indicated Resident #S was unable to feed herself and required staff assistance with eating.</p> <p>Interview with Confidential Family Member on 3/13/14 at 10:50 a.m., indicated there was not enough staff on the Linden Unit to provide the residents with the care they need, especially with dining and assisting the residents with eating. They indicated they have visited the Linden Unit at various times throughout the day and many times there was not a staff member present on the unit. They indicated they have a hard time finding staff to assist residents and answer questions. They indicated there used to be a staffing sign posted near the entrance to the unit that had the names of the staff working but the sign had not been posted for a long time. They indicated without the sign they don't even know who was working on the unit or who to look for if they need help.</p> <p>8. Interview with Resident #B on 3/11/14 at 9:05 a.m., indicated she had not received a shower in a while and was unsure if there was a shower schedule.</p> <p>Resident #B's record was reviewed on 3/11/14 at 10:15 a.m. The Resident's diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure.</p>			

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	<p>The Admission Minimum Data Set (MDS) Assessment, dated 2/4/14, indicated the resident required extensive assistance with personal hygiene and was totally dependent on staff for bathing.</p> <p>A care plan for activities of daily living (ADLs), dated 1/28/14, indicated the resident had a self care deficit and required extensive assistance to complete dependence with bed mobility, bathing, dressing, grooming, and toileting needs.</p> <p>The Pines South Shower Schedule indicated Resident #B was to receive a shower on Wednesday and Saturday on the day shift.</p> <p>Interview with CNA #6 on 3/11/14 at 10:05 a.m., indicated the shower schedule was located in the shower book on the unit and the schedule told staff which residents were to be showered each day. She further indicated all completed showers and bed baths were to be documented in the shower book.</p> <p>Review of the shower book and shower sheets on 3/11/14 at 10:30 a.m. indicated the following: 2/15/14-resident refused shower 3/5/14-resident refused shower</p> <p>There was lack of documentation to indicate the resident had been offered or received a shower on any dates other than 2/15/14 and 3/5/14.</p> <p>Interview with the Interim Director of Nursing (DoN) on 3/11/14 at 2:10 p.m., indicated CNAs were supposed to document completed showers on shower sheets. She further indicated she could not find any other</p>			

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	<p>documentation that Resident #B had received a shower or that a shower was offered to the resident on her scheduled shower days.</p> <p>9. Resident #D was observed continually on 3/10/14 from 4:55 p.m. until 7:15 p.m. At 4:55 p.m., she was seated in her Geri chair at a dining table adjacent to the TV area on Pines North. Resident #D was dozing intermittently with no other resident or staff interaction. A palm protector splint was in place to her left hand. At 5:20 p.m., the Activity Director sat at the table with Resident #D and several other residents and passed around a newspaper during which time there was no participation or interaction with Resident #D. At 6:15 p.m., Resident #D's food was set on the table in front of her. At 6:28 p.m., she was given one bite of food by CNA #1, who was also attempting to feed 3 other dependent residents at the same table. At 6:35 p.m., CNA #2 had finished passing out food and sat down to feed Resident #D and one other dependent resident. Resident #D was observed to be completely dependent for eating and drinking. At 7:15 p.m., Resident #D remained at the dining table, dozing, while CNA #1, CNA #2 and CNA orientee started taking other residents back to their rooms for evening care. No other CNA's were on the unit and the three CNA's were all working together with one resident at a time since all of the resident's in the Pines North dining area were dependent and required two staff for all Activities of Daily Living (ADL's) per CNA #1's verbal report. At 7:45 p.m., Resident #D remained in the same position in her chair at the table, sleeping. No resident or staff interaction. At 8:25 p.m., the Activity Director walked by and noticed Resident #D still sitting by herself at the table</p>			

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	<p>and wheeled her down to her room. Resident #D remained in her chair in the same position in her room until 8:52 p.m. when CNA #1 and CNA orientee arrived to provide evening care. Resident #D was transferred into her bed via Hoyer lift by the two above staff. The staff then put a gown on her to sleep, provided incontinent care as her brief was visibly wet with yellow urine, and called the nurse on staff to the room to change Resident #D's dressings to her right and left buttock due to stool soilage. Her buttocks was visibly red and wrinkles were noted to her buttocks and back. At 9:20 p.m., the nurse arrived and completed the dressing change to Resident #D's buttocks. Barrier cream was applied by the nurse before fastening her brief. Resident was repositioned in bed and her air mattress was in use and functioning.</p> <p>Resident #D was observed to be in the same position in her Geri chair from 4:55 p.m. until 8:52 p.m. without being repositioned by staff.</p> <p>During a continuous observation on 3/11/14 from 9:00 a.m. until 12:00 p.m., Resident #D was sitting in her Geri chair in the same position sleeping in front of the TV on Pines North. There was no staff or resident interaction during this time, except when CNA #3 rolled her chair to the dining table at 11:50 A.M.</p> <p>In an interview with CNA #1 and CNA #2 on 3/10/14 at 7:20 p.m., both indicated they had not moved or cared for Resident #D since before dinner.</p> <p>Confidential interview with various staff CNA's on 3/10/14 indicated their assignments were very heavy. The CNA's</p>			

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	<p>indicated there were 9 residents requiring a hooyer lift for transfers of completely dependent residents. The CNA's indicated the remaining residents required extensive assistance of 2 persons. The CNA's indicated they worked together to assist the residents who required assistance of two staff assist and at this time other residents were forced to wait until care of the other residents was completed.</p> <p>Both CNA's indicated residents were frequently upset about having to wait for evening care and they all seem to want to get ready for bed at the same time. Care was provided by the CNA's and the nurses do not help feed or change residents or answer call lights. They also indicated the CNA's on evenings always work through their lunch breaks and have to try to take a quick break after dinner, also when residents are wanting to go to bed.</p> <p>In an interview with LPN #1 on 3/11/14 at 11:28 a.m., she indicated "routine repositioning per policy" written in resident care plans meant to turn or reposition each resident every two hours. She was unsure if Resident #D had been repositioned since breakfast.</p> <p>In an interview with CNA #3 on 3/11/14 at 11:55 a.m., she indicated she had not cared for Resident #D since breakfast.</p> <p>Resident #D's record was reviewed on 3/11/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to: Alzheimer's dementia, depression, Parkinson's, Type 2 diabetes, subdural hematoma, and hemiplegia.</p>			

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	<p>Review of Resident #D's Minimum Data Set (MDS) Assessment dated 2/14/14 indicated the resident did not speak, her cognitive skills were moderately impaired indicating poor decisions and cues/supervision were required, she was always incontinent of bowel and bladder, and was totally dependent for all Activities of Daily Living (ADL's) including eating, toileting, hygiene/ bathing, bed mobility and transferring.</p> <p>Review of Resident #D's shower sheets for February and March indicated showers were given twice weekly throughout February. In March, the only shower recorded was on 3/4/14. This shower sheet could not be located by the DON on 3/11/14, however.</p> <p>During an interview on 3/11/14 at 2:10 P.M., the DON indicated all completed showers were to be charted on the shower sheets and there was no other documentation to indicate Resident #D received a shower any other time in March.</p> <p>Review of Resident #D's care plan for ADL's indicated the resident was dependent on others for all bathing, dressing and grooming needs related to her diagnosis of Alzheimer's disease</p> <p>Review of the care plan for pain indicated Resident #D had the potential for pain, was primarily nonverbal, and staff anticipated her needs. Approaches included position for comfort with physical support as necessary, provide routine repositioning, reclining geriatric chair, and monitor and record any non-verbal signs of pain.</p> <p>Review of the care plan for pressure ulcers indicated Resident #D was at risk for further</p>			

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	<p>pressure ulcers related to a history pf pressure ulcers, impaired mobility, and incontinence. She also had a history of recurrent excoriations to underside of breasts. Goals included pressure ulcer will heal without complication and risk of pressure ulcers would be reduced with use of interventions in place. Approaches included, but were not limited to, administer treatment to buttocks as ordered, cushion to Geri chair, off load heels while in bed, air mattress with gap reducing device, avoid shearing during repositioning, transferring and turning; keep as clean and dry as possible and minimize skin exposure to moisture; palm protector to left hand - check skin every shift and as needed; provide incontinence care after each episode; requires extensive assistance to complete dependence for routine positioning.</p> <p>A policy titled "Turning Schedule Policy" was provided by the DON on 3/11/14 at 2:10 p.m. and deemed as current. The policy indicated: "Residents who rely on staff for turning and repositioning will be turned every two hours on a continuous basis to promote circulation and prevent skin breakdown."</p> <p>10. Resident #P was observed no 3/10/14 continually from 4:55 p.m. until 7:30 p.m. At 4:55 p.m., the resident was in her Broda wheelchair in front of the TV on Pines North. At 5:05 p.m., staff wheeled her over to the dining table. At 5:20 p.m., the Activities Director sat down with other residents at an adjacent table & passed around the newspaper. At 5:25 p.m., the Activities Director pulled Resident #P over to join the group at the other table, however no direct interaction with the resident was noted and she was not interactive with the group. At 5:45 p.m., Resident #P was moved back to</p>			

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	<p>her table. No staff was present from 5:55 p.m. until 6:13 p.m. At 6:20 p.m., Resident #P's food was placed on the table in front of her and at 6:25 p.m. CNA orientee started feeding resident. Resident #P was observed to be completely dependent for feeding at this time. She finished at 7:00 p.m. and sat at the table until 7:15 p.m. when CNA #1 and CNA #2 took her back to her room for evening care. Care was observed in resident's room at this time. Resident #P was transferred to her bed by both staff using the hoier lift. A gown was placed on her and incontinence care done. Her brief was visibly soaked with yellow urine which could be seen through the brief before it was removed. Resident #P was also incontinent of stool at this time.</p> <p>Resident #P remained in the same position in her chair from 4:55 p.m. until 7:20 p.m.</p> <p>Resident #P's record was reviewed on 3/11/14 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia, malnutrition, failure to thrive and hyponatremia.</p> <p>Review of the daily ADL's charting for Resident #P indicated she was completely dependent for eating, toileting, hygiene/ bathing, bed mobility and transferring.</p> <p>Resident #P's care plans included, but were not limited to the following identified problems: ADL deficit, urinary incontinence related to incontinence and impaired mobility, risk for pressure ulcers, and a communication deficit related to her diagnoses of dementia and dysphagia Approaches included hoier lift for all transfers - two assist; avoid shearing during</p>			

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F000441 SS=E	<p>positioning, transferring and turning; extensive assistance to complete dependence for routine repositioning - use positioning devices as needed; keep clean and dry as possible - minimize skin exposure to moisture; routinely check and provide incontinence care after each episode.</p> <p>A policy titled "Turning Schedule Policy" was provided by the DON on 3/11/14 at 2:10 p.m. and deemed as current. The policy indicated: "Residents who rely on staff for turning and repositioning will be turned every two hours on a continuous basis to promote circulation and prevent skin breakdown."</p> <p>This deficiency was cited on January 29, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(2)(B) 3.1-38(a)(2)(C) 3.1-38(a)(2)(D) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>			

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	<p>resident; and</p> <p>(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, record review, and interview, the facility failed to prevent the spread of infection related to changing suction canisters, wearing gloves or washing hands during the administration of medications, and disposing of soiled gloves for 3 residents in the sample of 21. (Residents #E, #F, #L, and #H) (RN #2) (CNA's #2 and #4)</p> <p>Findings include:</p> <p>1. On 3/11/14 at 1:25 p.m., CNA #4 and CNA #8 were observed transferring Resident #F from the wheelchair into her bed. The CNA's then removed the resident's pants and</p>	F000441	F 441 Infection Control, Prevent Spread, LinensRESIDENTS FOUND TOHAVE BEEN AFFECTED:The staff of thefacility makes every effort to ensure the prevention of the spread of infectionrelated to changing suction canisters, wearing gloves and washing hands duringthe administration of medications and disposing of soiled gloves. Four residents were identified, resident #E,#F, #L and #H. All identified residents received immediate a change of theircanister if appropriate, tubing and appropriate infection control measures.OTHER RESIDENTSPOTENTIALLY	04/12/2014

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	<p>they both removed the resident's brief. The brief was wet with urine. The CNA's then cleansed the resident and applied a clean brief. Both the CNA's wore disposable gloves while providing incontinence care. CNA #4 removed his gloves and exit the room holding the gloves in his hand. The CNA then walked down to the other end of the hall and opened the door of the utility room. The CNA then threw the glove into the trash can in the room.</p> <p>The record for Resident #F was reviewed on 3/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, arthritis, osteoporosis dementia, Parkinson's, dysphasia (difficulty swallowing) and depression.</p> <p>Review of the 2/26/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident BIMS(Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive pattern were moderately impaired. The assessment also indicated the resident required extensive assistance of two or more staff members for transfers. The assessment also indicated the resident required extensive assistance of one staff member for dressing and eating and was totally dependent on one staff member for toilet use and personal hygiene.</p> <p>2. On 3/10/14 at 8:25 a.m., RN #2 was observed standing by a Medication Cart in the Timber floor Dining Room. The RN was withdrawing a medication from vial. RN #2 the walked over and sat down next to Resident #H. The RN then gave the resident eye drops. The RN was not wearing gloves. The RN then gave the resident an injection in her abdomen. The RN was not wearing</p>		<p>AFFECTED: An audit of staffhand washing techniques using the policy of the facility entitled "Hand Hygiene Policy" has been conducted to ensure staff is knowledgeable of the stepsinvolved in proper procedure of using gloves and hand washing. An audit has also been conducted of all suction canisters for appropriateness of date. SYSTEMIC MEASURES/ CORRECTIVE ACTION: The staff has been inserviced on the facility "Hand Hygiene Policy", and dates and changing of suction canisters and tubing. QUALITY ASSURANCE/ MONITORING: The Director of Nursing or designee will audit the employee's hand washing techniques and check canisters and tubing for appropriate dates three times per week for four weeks, then two times per week for 4 weeks, then one time weekly for 4 weeks and then one time weekly for one quarter. The audit results will be forwarded to the QA Committee. The QA Committee will determine if further auditing is warranted. DATE OF COMPLETION: April 12, 2014</p>				

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	<p>gloves. RN #2 did not wash her hands between giving the eye drops and the injection. The RN then returned to he medication cart.</p> <p>The record for Resident #H was reviewed on 3/12/14 at 3:00 p..m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, insulin dependent diabetes mellitus, and glaucoma.</p> <p>Review of the 3/2014 Medication Administration Record indicated there were Physician orders for the resident to receive Latanoprost eye drops daily at bed time (8:00 p.m.) to both eyes. There was also an order for the resident to receive 45 units of Lantus insulin injected subcutaneous at bedtime (8:00 p.m.) daily.</p> <p>When interviewed on 3/10/14 at 8:35 p.m., RN #1 indicated she had just given Resident #H and eye drops and an injection of Lantus insulin. The RN indicated she usually wears gloves when administering eye drops and insulin injections and she should have been wearing them.</p> <p>3. During Orientation Tour on 3/10/14 at 8:15 p.m., Resident #L was observed in bed. The resident had a stoma (opening) in his trachea. There was a suction machine on the dresser next to the resident's bed. The suction canister was approximately 1/2 full with suctioned secretions. The tubing attached to the canister was dated 3/2/14. There was a plastic bag with a suction catheter used to suction the resident's oral airway on the table. The bag was opened and there was a date of 2/22/14 on this bag. RN #4 was present at this time and confirmed the date of 3/2/14. The RN</p>			

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	<p>indicated she had not suctioned the resident on this shift today.</p> <p>The record for Resident #L was reviewed on 03/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), peg tube (tube in stomach for nutrition), history of tracheostomy(opening in throat to breath), and traumatic brain injury.</p> <p>Physician's Orders, originally dated 09/06/13, included for staff to provide Stoma(opening in throat) care each shift and PRN (as needed), suction stoma each shift and PRN and change suction canister daily on the 11:00 p.m.-7:00 a.m. shift.</p> <p>4. The evening meal service on the Pines North unit Day/Dining Room area was observed on 3/10/14 from 6:00 p.m. thru 7:15 p.m. Facility staff began serving the residents' meal trays at 6:13 p.m. when the meal cart arrived to the Unit.</p> <p>During this time, CNA #2 was observed sitting down between Residents #E and #F. At 6:25 p.m., the CNA was observed getting up from the feeding the above two resident and walked over to Resident #K's table. CNA #2 then picked up 1/2 of Resident #K's sandwich and gave it to the resident to hold. The CNA was not wearing gloves at this time. The CNA did not wash her hands between leaving the first table and picking up Resident #K's sandwich. The CNA then took off her net and through the hairnet in the trash can. The CNA used alcohol gel to her hands and then returned to feed other residents. The CNA then got up from feeding Residents #E and #F and went to the window to open the window. The CNA was not wearing gloves</p>			

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	<p>while feeding and did not gel or wash her hands between opening the window and returning to feed the residents. During this time, the CNA was also observed wiping her face with her hands, pushing her hair behind her ears, and resuming feeding and cueing residents without gloves or completing any hand hygiene. CNA #2 was also observed during this time to stand and adjust her pants and then resumed feeding residents without wearing gloves or completing any hand hygiene. The CNA was also observed picking up Resident #E's plate, wiped the table, took the resident's tray and placed it in food cart and returned to the table to continue to feed Resident #E. The CNA was not wearing gloves and did not complete any hand hygiene at this time.</p> <p>The facility policy titled "Hand Hygien Policy and Procedure" was reviewed on 3/11/14 at 2:40 p.m. There was no date on the policy. The Interim Director of Nursing provided the policy and indicated the policy was current. The policy indicated hand washing was to be completed after removing gloves. The policy also indicated gloves were to be worn when contact with blood or other body fluids, secretions and excretions, would or could occur.</p> <p>When interviewed on 3/10/13 at 10:30 p.m., the Interim Director of Nursing indicated gloves were to be worn during the administration of eye drops.</p> <p>This Federal tag relates to Complaint IN00142795.</p> <p>This deficiency was cited on January 29, 2014. The facility failed to implement a systemic plan of correction to prevent</p>			

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	recurrence. 3.1-18(a)			