

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
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NAME OF PROVIDER OR SUPPLIER  JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F0000	<p>This visit was for Investigation of Complaint IN00120819.</p> <p>Complaint IN00120819 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: December 18 and 19, 2012</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 13 Medicaid: 89 Other: 8 Total: 110</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		
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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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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to plan and implement services, including timely consultation at the wound care center, to prevent and treat pressure ulcers for a resident who entered the facility with a Stage 4 pressure ulcer. The resident developed a second pressure ulcer staged by the facility as Stage 3. The deficient practice affected 1 of 3 residents reviewed related to risk for pressure ulcers in a sample of 4 residents. (Resident D)</p> <p>Findings include:</p> <p>On 12/18/12 at 1:00 p.m., CNA #14 was observed providing care for Resident D. The resident had been incontinent of soft brown stool. During interview at this time, CNA #14 indicated this was the second day she had cared for Resident D, and the third time the resident had been</p>	F0314	<p><b>F 314 TREATMENT/SVCS TO PREVENT /HEAL PRESSURE SORES SS=G</b></p> <p><b>1. Resident D's physician was notified by licensed nurse of residents pain associated with a diagnosis of peripheral neuropathy with orders received on 12/18/2012.</b></p> <p><b>Urinalysis was obtained and orders received on 12/17/2012.</b></p> <p><b>Labs ordered 12/19/2012 to include CBC (Complete Blood Cunt), CMP (Complete Metabolic Panel), Iron Level, TIBC (Total Iron Binding Capacity), Pre Albumin, Amylase, Lipase and drawn 12/19/2012 Physician notified of lab results and orders received 12/21/2012</b></p> <p><b>Appointment scheduled for</b></p>	01/18/2013			

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	<p>incontinent of stool today. She indicated the nurse would come in to change dressings on the resident's wounds which were soiled with stool. As the resident's buttocks were cleansed, two soiled dressings were observed - one on the sacrum and one on the right gluteal fold. Visible on the sacrum was a partially taped abdominal (ABD) pad, soiled with some stool, and on the gluteal fold, the ABD pad covering the wound was off, and the packing in the wound was covered on the visible part with stool. The resident's buttocks were reddened, and a reddened indentation was observed on the left inner thigh. The area around the sacral wound was a deep reddish-purple color, and the buttocks next to the cleft on both sides were a deep reddish-purple color. The resident was wearing padded socks, and his heels were directly on the specialty mattress. CNA #14 indicated she would call the nurse into the room, and LPN #17 and CNA #22 entered. LPN #17 brought a medication cup filled with liquid and gauze. During interview at this time, LPN #17 indicated the cup contained sterile water and gauze for packing the gluteal fold. She indicated a Flagyl (antibiotic) tablet was crushed and dissolved in water and used for the gauze packing one time a day, and the packing is changed only if soiled with stool. LPN</p>		<p><b>Urology</b> <b>Consult related to super pubic malfunction.</b></p> <p><b>Care Plans were reviewed and revised by IDT which consists of Director of Clinical Services, Social Services, Registered Dietician, and Director of Activities.</b></p> <p><b>2. Skin sweeps were done on current resident population.</b></p> <p><b>3. Licensed staff re-educated by a RN consultant on Policy and Procedure of skin care and wound management.</b></p> <p><b>New admissions will be reviewed in the next clinical review meeting to ensure identification of services needed to manage wounds have been addressed.</b></p> <p><b>Weekly skin integrity checks will continue to be completed on residents by licensed staff to ensure any new areas are identified and treated according to Physicians orders.</b></p> <p><b>Unit Manager/Assistant Director of Clinical Services will QI monitor weekly skin integrity checks for completion.</b></p>				

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	<p>#17 removed the packing. The wound was not cleansed, and the fresh packing was inserted into the wound. An ABD pad was placed over the wound and taped. LPN #17 indicated the sacral wound required only a fresh ABD pad, since only the pad was soiled with stool, and the soiled pad was removed and a fresh pad was applied and taped. Smudges of stool were observed on the bed clothes beneath the buttocks. When interviewed in regard to Resident D's heels, LPN #17 indicated the resident had no heel wounds. The resident was rolled to the left, and a wedge cushion was placed behind his back. No pillows were placed between the knees, and the heels were not floated. The resident moaned whenever he was moved, and as the wounds were dressed.</p> <p>During interview on 12/18/12 at 2:30 p.m., the Director of Nursing (DON) indicated she was preparing to measure Resident D's wounds, because she did not think the most recent measurement of 10 cm. width was accurate on the wound tracking sheet for the gluteal wound. At this time, the DON entered the resident's room and prepared to measure the wounds. The resident was lying on the left side, with a wedge cushion behind his back. The DON indicated the resident's brief had stool on it, so staff would provide care, and then she would measure</p>		<p><b>The wound care team, which consists of the Director of Clinical Services, Dietary, Certified Nursing Assistant, and Therapy(as indicated) will assess and measure wounds weekly to determine the continued treatment and or the need for physician notification/treatment change. Referrals for outside wound consults will be discussed at the wound care team meeting and followed up on accordingly.</b></p> <p><b>Care Plans will be reviewed and revised as indicated to reflect current course of treatment.</b></p> <p><b>4. The Administrator/designee will QI monitor weekly wound/skin meetings to ensure that follow up on current wound care is achieved. Findings will be brought to the monthly QAPI for review and development of action plan to ensure facility plans and implements services to prevent and treat pressure ulcers</b></p> <p><b>1/18/2013.</b></p>		

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	<p>the wounds. The DON told the resident his pain medication had just been increased. The resident's heels were on the mattress. When interviewed in regard to the resident's heels on the mattress, the DON indicated the resident "did [previously] have bad heels," and "has boots" which may have been discontinued. At 2:45 p.m., CNA #10 and CNA #4 entered to provide care for the resident. As the CNAs rolled the resident to his back to provide care, a reddened area was observed along the length of the left shin, where the legs had been skin to skin. The ABD pads covering the wounds were soiled with very soft light brown stool, and the packing in the gluteal wound was observed to be brown with stool when it dislodged from inside the wound as CNA #10 cleansed the resident's buttocks. During interview at this time in regard to the redness and excoriation on the resident's buttocks, CNA #10 indicated sometimes the buttocks are red and sometimes not. As the wound was revealed, the DON indicated it was "bigger than I've seen it." The DON indicated the skin below the sacral wound and onto the buttocks was "more dusky." The area on the right and left buttocks near the cleft were observed to be a dark purple under the skin. The DON pressed her fingers over the area, and she</p>			
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	<p>indicated the area "blanches near the edges." The DON indicated the gluteal wound needed to be cleansed with normal saline and supplies were obtained. Using several prefilled syringes, the DON irrigated the gluteal wound and indicated the "tissue needs debridement." Observed deep within the wound was white substance on one area. The DON indicated the substance was the crushed Flagyl. The DON indicated the resident's wounds are discussed weekly at a team meeting, and she and another nurse "do the measurements." The DON used a centimeter ruler on the edge of a gauze dressing package, and indicated she would measure "just the opening" of the gluteal wound. She indicated she would not measure the depth of the wound at this time. The DON indicated if she measured the open area and the "abraded [sic]" area the wound would be 6.4 cm by 7 cm. LPN #17 worked with the DON to complete the wound care. After the wounds were redressed, CNA #4 and CNA #10 completed care. The resident was rolled onto the left side with a wedge cushion behind his back. CNA #10 indicated the resident is turned every two hours, and he is checked on every hour.</p> <p>During observation of Resident D on 12/19/12 at 1:00 p.m., he was wearing AFO (ankle foot orthotic) splints which</p>				

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	<p>suspended his heels off of the bed. CNA #6 was providing care at this time. She indicated the resident was not wearing the AFO splints when she came on duty at 6:00 a.m., but she had placed the splints on the resident.</p> <p>The clinical record for Resident D was reviewed on 12/18/12 at 2:00 p.m. The record indicated the resident was admitted from the hospital to the facility on 9/26/12. The hospital Transfer Summary, dated 9/26/12, indicated diagnoses including, but not limited to, "...paraplegia and chronic pain/low back pain, multiple decubitus ulcers especially a stage IV sacral decubitus ulcer, severe protein-calorie malnutrition, anemia of chronic disease/iron deficiency...."</p> <p>The Pressure Ulcer Record for the wound present upon admission indicated the site of the wound was the coccyx, and the description on 9/26/12, was Stage 4 with measurements of 4 by 2.8 by 2.1 centimeters, positive for drainage, no odor and positive for granulation tissue. The treatment was indicated to be a wound vac.</p> <p>Nurse's Notes, dated 10/13/12 at 5:00 p.m., indicated the wound vac was discontinued.</p>			

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	<p>A physician's order, dated 10/12/12, indicated, "NS [normal saline] wet to dry drsg [dressing] to O/A [open area] on coccyx. [Symbol for change] q [every] day and PRN [as needed] for dislodgement/soiled until evaluated by wound team."</p> <p>The description grid for the wound indicated the following on the dates indicated: 10/6/12 - 3.8 x 2.8 x 2 cm (length by width by depth), no odor, no undermining, granulation tissue; 10/23/12 (This was the next measurement indicated.) - 5 x 4.2 x 2.1 cm, no drainage, no odor, undermining at 6 and 12 (o'clock), granulation tissue. Weekly measurements continued from 10/30 through 12/11/12 with the smallest length of wound on 11/21/11 at 4.2 cm, the smallest width of the wound on 11/15/12 at 2.8 cm, and the smallest depth of wound on 11/21/12 at 1.2 cm. On 12/11/12, the wound measured 4.8 x 3.2 x 2.2 cm.</p> <p>A Nurse's Note, dated 10/6/6/12 at 9:00 p.m., indicated, "...Noted O/A to R [right] buttocks. Center red, non-blanching. Profound white in color...."</p> <p>A Skin Grid - Pressure document, dated 10/6/12, indicated, a picture of a man with a circle on the gluteal fold of the</p>			

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	<p>right buttock. The documentation indicated a 3 cm by 2 cm Stage 1 pressure ulcer with no depth and red color. The measurements and wound stage for 10/10/12 were the same, with granulation tissue in the wound bed. On 10/16/12, the Visualized Stage of the wound was Stage 2 and the Wound Bed included granulation tissue and yellow slough. Measurements on the grid continued as follows: 10/23/12 - 1 X 2.5 X &lt; (less than) 0.1; 10/30/12 - 2.1 X 2.9 X 0.8 cm with yellow slough; 11/6/12 - 3.4 X 3.2 X 1.4 cm with yellow slough; on 11/15/12 - the staging of the wound indicated Stage 3, with measurements of 4.5 X 3.8 X 1.8 cm and yellow slough in the wound bed; 11/21/12 - 4.3 X 3.0 X 1.7 with yellow slough; 11/29/12 - 2.8 X 3.8 X 1.7 cm with a small amount of serous drainage, and granulation tissue and yellow slough; 12/5/12 - 2.8 X 3.8 X 1.7 with a small amount of serous drainage with odor present, with granulation tissue and slough; and 12/11/12 - 6.0 X 10.0 X 2.2 cm, no drainage, with odor present, slough and eschar in the wound bed.</p> <p>A physician's order, dated 10/16/12, indicated, "Exuderm to R gluteal fold. [Symbol for change] Q3d [every three days] &amp; PRN [as needed]."</p> <p>A physician's order, dated 10/23/12,</p>						

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	<p>indicated, "1. DC [discontinue] Exuderm to R gluteal fold. 2. Ca+ [calcium] Alginate et [and] cover [with] bordered gauze. [Symbol for change] Q3days et PRN to R gluteal fold."</p> <p>A physician's Progress Note, dated 11/1/12 indicated, "...Skin...He has large non-healing sacral decubitus ulcer and a smaller one on the upper inner thigh/gluteal area..." and "Assessment and Plan...Wound care consult for his non-healing wounds...."</p> <p>A physician's order, dated 11/1/12, included, but was not limited to, "Wound care consult (Dx [diagnosis]: sacral decub)...". A handwritten notation indicated, "Notified [name of wound care center] 11/1/12."</p> <p>A Narrative Note, signed by the DON, undated and untimed, at the end of the "Care Track (Multi Shift)" documentation for 11/5/12, indicated, "Dis [discussed] upcoming procedure [with] wife. She is requesting that [name of Resident D] undergo procedure for S/P [suprapubic] cath [catheter] [before] F/U [follow-up] with wound clinic. States 'appts [appointments] are very difficult for [name of Resident D] physically.'"</p> <p>A Narrative Note for 11/6/12 at 4:30 p.m.,</p>			

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	<p>indicated the resident returned to the facility after placement of the suprapubic catheter.</p> <p>A physician's order received 12/10/12 was clarified on 12/11/12 as follows: "Apply crushed Flagyl 500 mg to gluteal fold wound bed. Pack [with] NS [normal saline] wet to dry QD [daily]. Cover [with] ABD pad. [Change] ABD pad prn for soiling. Only [change] wet to dry PRN if packing is soiled [with] BM [bowel movement]."</p> <p>A Care Review/Progress Review, dated 12/13/12, and signed by the Social Services Director (SSD), indicated attendees of Responsible Party, Director of Nursing Services, Social Services, and Other (with no name indicated). A check mark was next to "Reviewed progress towards goals and variances," and handwritten was, "Discussed plans to go to wound clinic...." In the section for Notes was indicated, "...[resident's wife] also says a wound clinic appt. was supposed to have been set after 11/8/12 mtg [meeting]. SSD will f/u with DON &amp; Administrator." The signature space for the resident and resident's family included the names of the resident and his wife.</p> <p>Copy of a faxed Outpatient Referral Request, dated 12/14/12, indicated the</p>			

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	<p>resident was being referred for "Wound care evaluation with follow-up treatment" for "Chief Complaint: Coccyx wound unchanged since admit. Gluteal wound deteriorating."</p> <p>The Physical Therapy Discharge Summary, dated 12/3/12, indicated in "Summary of Care: Skilled Services: Skilled interventions addressed in this reporting period....Therapeutic exercise...to reduce risk of skin breakdown....Summary of Progress...Initiated RMP/FMP [restorative/functional maintenance plan] for...application of resting splint for bl [bilateral] ankle."</p> <p>During interview on 12/19/12 at 5:00 p.m., the Assistant Director of Nursing (ADON) showed the CNA Resident Profile for care of Resident D in the kiosk computer system. The Profile indicated, "To wear ankle/foot splint/brace for heels up and foot drop."</p> <p>During interview on 12/19/12 at 3:10 p.m., the DON indicated therapy recommended the splints for Resident D. She indicated there was no physician's order for the splints. The DON also indicated Resident D has an appointment for the wound consult on 12/26/12.</p>			

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	This federal tag is related to Complaint IN00120819.  3.1-40(a)(1)				

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NAME OF PROVIDER OR SUPPLIER  JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
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F0315 SS=D	<p><b>483.25(d)</b> <b>NO CATHETER, PREVENT UTI, RESTORE BLADDER</b></p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to provide care as ordered for a resident with history of urinary tract infection and recently placed suprapubic catheter. The deficient practice affected 1 of 1 resident reviewed related to suprapubic catheter in a sample of 4. (Resident D)</p> <p>Findings include:</p> <p>On 12/18/12 at 1:00 p.m., CNA #14 was observed providing care for Resident D. CNA #14 removed the resident's brief, which was soiled with soft brown stool. Resident D was observed to have a suprapubic catheter leading to a urinary drainage bag at the side of the bed. No dressing was on the suprapubic tube site, and no leg strap attached the tubing to the resident's leg. During the care, LPN #17 provided dressing changes to Resident D's</p>	F0315	<p><b>F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER SS=D</b></p> <p><b>1. CNA # 10, 4, 22, 6, 14 LPN #17 were re-educated on super pubic catheter care.</b></p> <p><b>Urinalysis obtained 12/17/2012 by licensed staff per physician order with medication ordered to treat urinary tract infection for resident D.</b></p> <p><b>Appointment scheduled with urology clinic and surgeon for 12/26/2012. Resident expired 12/25/2012.</b></p> <p><b>2. Facility has conducted QA review and determined no other supra pubic catheters are utilized in the facility.</b></p> <p><b>3. Licensed staff re-educated by the Director of Clinical</b></p>	01/18/2013			

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	<p>decubitus wounds. The suprapubic catheter site was not dressed by LPN #17 at this time.</p> <p>On 12/18/12 at 2:45 p.m., CNAs #10 and #4 were observed providing care for Resident D, who had been incontinent of stool. CNA #10 indicated the resident had just started using briefs in the last couple of days when urine began leaking from his penis as well as coming through the catheter. The resident's suprapubic catheter site was not dressed, and the area around the opening was dark red, and crusty dark red secretion was dried around the tubing. No leg strap attached the tubing to the resident's leg. The Director of Nursing (DON) was in the room providing wound care. As CNAs #10 and #4 rolled Resident D for care, the DON indicated, "Be careful of his tubes."</p> <p>On 12/19/12 at 12:55 p.m., the DON and LPN #17 entered Resident D's room. During interview at this time, LPN #17 indicated she had a leg strap for Resident D's suprapubic catheter, and she placed a small package on the bedside table. The DON indicated it "looks like the resident's catheter is working some, but not completely." The DON indicated the resident needed personal care, and the nurses left the room. CNA #6 entered the room at 1:00 p.m. to provide care. During</p>		<p><b>Services/Assistant Director of Clinical Services on following physician orders and the management of super pubic catheters to prevent urinary tract infections.</b></p> <p><b>Non licensed staff re-educated by the Director of Clinical Services/Assistant Director of Clinical Services on provision of incontinent care for residents with indwelling catheters.</b></p> <p><b>Licensed staff re-educated by a RN consultant on Policy and Procedure of skin care and wound management</b></p> <p><b>Director of Clinical Services and or Assistant Director of Clinical Services will visually QI monitor provision of incontinent care to residents with supapubic catheters through return demonstration.</b></p> <p><b>4. The Director of Clinical Services will QI monitor provisions of incontinent care for new hires and current direct care staff with in the next quarter through skills check off and return demonstration.</b></p> <p><b>The Administrator/designee will QI monitor weekly wound/skin meetings to ensure</b></p>				

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	<p>interview at this time, she indicated she provided care for Resident D often, and he did not use a leg strap for his catheter tubing. As care was provided, the resident was observed to have no dressing on his suprapubic tube insertion site. CNA #22 assisted CNA. #6. When care was completed, the packaged leg strap for the catheter was lying on the bedside table.</p> <p>The clinical record for Resident D was reviewed on 12/18/12 at 2:00 p.m. The record indicated the resident was admitted from the hospital to the facility on 9/26/12. The hospital Transfer Summary, dated 9/26/12, indicated diagnoses including, but not limited to, "...urinary tract infection with sepsis from Escherichia coli and again urinary tract infection with yeast...."</p> <p>An outpatient Patient Discharge Transfer/Referral Form, dated 11/6/12, indicated, "...suprapubic tube placement. Follow appropriate suprapubic catheter care regimen...."</p> <p>The Interdisciplinary Care Plan for Indwelling Urinary Catheter, dated 9/28/12, and updated 11/6/12, with the "Problem: SP [suprapubic] placed today" indicated Interventions including, but not limited to, "Avoid tugging on the</p>		<p><b>that follow up on current wound care is achieved. Findings will be brought to the monthly QAPI for review and development of action plan to ensure facility plans and implements services to prevent and treat pressure ulcers.</b></p>				

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	<p>catheter."</p> <p>A physician's order, dated 11/29/12, indicated, "...Cleanse suprapubic catheter &amp; stoma [with] NS [normal saline]. Apply Bacitracin &amp; drain sponge q [every] shift to stoma."</p> <p>A Physician's Progress Note, signed by the Nurse Practitioner, dated 12/11/12 at 7:00 p.m., indicated, "...also has suprapubic cath [catheter] erythematous around insertion site. [Symbol for no] drsg [dressing]. Cath sl [slightly] pulling...."</p> <p>Physician's orders, dated 12/11/12, indicated, "...Apply drain sponge to suprapubic site [after] cleansing and obtain Velcro leg stabilizer for F/C [Foley catheter] tube (catheter being pulled not stabilized)...."</p> <p>The Treatment Flow Sheet for December 2012 indicated the following entry for 12/11/12: "Apply drain sponge to suprapubic site after cleansing and obtain velcro leg stabilizer for tubing." The order was signed off by a nurse's initials to indicate the order was completed on the 7:00 a.m. to 3:00 p.m. shift on 12/12/12 through 12/18/12.</p> <p>A physician's order, dated 12/18/12,</p>				

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	indicated the resident was to be started on an antibiotic for urinary tract infection.  3.1-41(a)(2)			

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F0322 SS=D	<p><b>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was planned for the resident's gastrostomy feeding tube site for 1 of 1 resident reviewed related to gastrostomy tube care in a sample of 4. (Resident D)</p> <p>Findings include:</p> <p>On 12/18/12 at 2:45 p.m., CNAs #10 and #4 were observed providing personal care for Resident D. The resident's gastrostomy tube site was observed to have no dressing, and the area around the site was red and with dark red crustiness.</p> <p>On 12/19/12 at 12:55 p.m., LPN #17 and the Director of Nursing entered Resident D's room. LPN #17 indicated the resident "needs everything." Neither nurse brought dressing supplies, and no dressing supplies were observed in the room.</p>	F0322	<p><b>F322 NG TREATMENT/SERVICES-RESTORE EATING SKILLS SS=D</b></p> <p><b>1. LPN #17 was re-educated by the Assistant Director of Clinical Services on gastrostomy tube site care.</b></p> <p><b>CNA #6 was re-educated by Assistant Director of Clinical Services on reporting residents with soiled dressings.</b></p> <p><b>2. Licensed staff conducted a QA review/assessment of residents with gastrostomy tubes for signs/symptoms of infection. Physician notified if indicated.</b></p> <p><b>3. Licensed staff re-educated by Director of Clinical Services and or Assistant Director of Clinical Services on Policy and Procedure addressing management of gastrostomy tube and skin care.</b></p> <p><b>Non –Licensed staff re-educated by Director of Clinical Services and or the assistant Director of Clinical Services on provision of care to residents with</b></p>	01/18/2013			

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	<p>On 12/19/12 at 1:00 p.m., CNA #6 was providing personal care for Resident D. No dressing was observed on the resident's gastrostomy tube site. During interview at this time, CNA #6 indicated a gauze sponge around the resident's gastrostomy tube site was wet "this morning" so she took it off. CNA #6 indicated the resident was wet with urine at 7:00 a.m., 11:00 a.m., and now.</p> <p>The clinical record for Resident D was reviewed on 12/18/12 at 2:00 p.m. The record indicated the resident was admitted from the hospital to the facility on 9/26/12. The hospital Transfer Summary, dated 9/26/12, indicated the resident would be fed by gastrostomy tube.</p> <p>The "Plan of Care: Skin - Other," dated 9/28/12, indicated the Goal: "G [gastrostomy] tube site will be free of S/S [signs and symptoms] infection." No interventions were specific to care of the gastrostomy tube site.</p> <p>The physician's rewrite orders for December 2012 included, but were not limited to, "Change dressing on G-tube 2 times a day after cleansing with saline &amp; apply Bactroban."</p> <p>A Physician's Progress Note, signed by</p>		<p><b>gastrostomy tubes. Assistant Director of Clinical Services will visually QI monitor licensed staff on provision of site care to residents with gastrostomy tube daily 5times a week for one month then weekly. Ongoing. Assistant Director of Clinical Services will visually QI monitor non licensed staff on provision of incontinent care to residents with gastrostomy tubes daily 5 times a week for one month then weekly. Ongoing. 4. The Director of Clinical Services will visually QI monitor licensed staff on provision of site care to residents with gastrostomy tubes weekly for 1 month then monthly. Ongoing Findings will be brought to QAPI for review and development of action plan to ensure care is provided to residents with gastrostomy tubes.</b></p>		

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	<p>the Nurse Practitioner, dated 12/11/12 at 7:00 p.m., indicated, "...GT [gastrostomy tube] patient sl [slightly] erythematous around site...."</p> <p>A physician's order, dated 12/11/12, included, but was not limited to, "...Apply drain sponge around GT site [after] cleansing."</p> <p>The Treatment Flow Sheet for December 2012 indicated the physician's order for gastrostomy tube dressing changes had been completed twice daily on the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts from 12/1 though the day shift on 12/18/12.</p> <p>During interview on 12/19/12 at 4:30 p.m., the DON indicated she would request the physician's orders for the drain sponges to include taping the dressing in place.</p> <p>3.1-44(a)(2)</p>						

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F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and</p>	F0441	<b>F441 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>	01/18/2013			

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	<p>record review, the facility failed to ensure staff followed infection control policies related to handwashing and glove use for 3 of 4 residents observed during care in a sample of 4. (Residents A, C, and D)</p> <p>Findings include:</p> <p>1. A. On 12/18/12 at 1:00 p.m., CNA #14 was observed providing care for Resident D. During interview at this time, CNA #14 indicated she would need to call the nurse to redress the resident's wounds, as she cleansed soft brown stool from the resident's buttocks. CNA #14 removed her gloves, and opened the door to call the nurse. Without washing her hands or using hand sanitizer, CNA #14 donned clean gloves and proceeded to provide care.</p> <p>B. On 12/18/12 at 2:45 p.m., CNA #10 and CNA #4 were observed providing incontinent care for Resident D. Both CNAs were wearing gloves. The Director of Nursing (DON) was in the room for wound assessments. CNA #10 cleansed stool from the resident's buttocks, and CNA #4 assisted with positioning the resident. More supplies were needed, and CNA #4 removed her gloves, and without washing her hands or using hand sanitizer started to exit through the door. Around the resident's</p>		<p><b>SS=D</b></p> <p><b>1. CNA's # 14,10,4,6,22,18, and 24 were re-educated by the Assistant Director of Clinical Services on hand washing and glove use.</b></p> <p><b>Resident A was assessed by licensed staff member on signs/symptoms of urinary tract infection. Physician notified as indicated.</b></p> <p><b>Resident C assessed by licensed staff member on signs/symptoms of urinary tract infection. Physician notified as indicated.</b></p> <p><b>2. Residents requiring provision of incontinent care assessed for signs and symptoms of urinary tract infection.</b></p> <p><b>Physician notified as indicated.</b></p> <p><b>Care plans reviewed/revised by the interdisciplinary team consisting of nursing, dietary, social services and activities.</b></p> <p><b>3. Nursing staff re-educated by the Director of Clinical Services/Assistant Director of Clinical Services on hand washing and glove use, management of infection control during transfers with</b></p>				

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	<p>bed curtain, the DON was observed coaching CNA #4 to wash her hands, mouthing the words, "Wash your hands" and motioning as if washing.</p> <p>C. On 12/19/12 at 1:00 p.m., CNA #6 and CNA #22 were observed providing incontinent care for Resident D. Resident D had been incontinent of urine. Both CNAs were wearing gloves. During care, supplies were needed. CNA #22 removed her gloves, and without washing her hands or using hand sanitizer, she left the room and returned with a draw sheet. CNA #22 donned clean gloves. CNA #6 completed care, removed her gloves, washed her hands, donned clean gloves, and provided mouth care. After the mouth care, CNA #6 removed her gloves, and without washing her hands or using hand sanitizer, donned clean gloves. CNA #22 and CNA #6 positioned the resident and wiped the soiled mattress with cleansing wipes. CNA #6 asked CNA #22 to hand her the cap to the mouthwash, which she placed on the bottle. CNA #22 removed her gloves, and without washing her hands or using hand sanitizer, placed the resident's call light on his chest on top of the bed covers.</p> <p>2. On 12/18/12 at 1:30 p.m., CNA #22 and CNA #14 were observed providing incontinent care for Resident A. The</p>		<p><b>Hoyer Lift and incontinent care.</b></p> <p><b>Unit Manager/Assistant Director of Clinical Services will visually QI monitor nursing staff on hand on hand washing and glove use, management of infection control during transfers with Hoyer Lift and incontinent care 3 times a day 5 times a week for 1 month and then weekly. Ongoing</b></p> <p><b>Any negative findings will be addressed immediately.</b></p> <p><b>4. Director of Clinical Services will visually QI monitor 10% of licensed staff weekly 1 time a month then monthly – ongoing on hand washing and glove use during provisions of incontinent care and during the utilization of Hoyer Lifts during transfers.</b></p> <p><b>Findings will be brought to QAPI (Quality Assurance Performance Improvement) monthly for review and development of action plan to ensure infection control is managed through appropriate hand washing and glove use.</b></p>				

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	<p>resident had been incontinent of bowel and bladder. CNA #22 cleansed the resident, and CNA #14 assisted with positioning. Wearing the same gloves as used for cleansing, CNA #22 applied the clean brief, arranged the resident's bed covers, and pulled back the resident's bed curtain. CNA #14 removed her gloves, and without washing her hands or using hand sanitizer, pulled back the resident's bed curtains. When care was completed, both CNAs entered the rest room to wash their hands.</p> <p>3. On 12/18/12 at 4:35 p.m., CNA #18 and CNA #24 were observed providing incontinent care and transfer by Hoyer lift for Resident C. The CNAs washed their hands and applied gloves. Without changing gloves or washing the hands, the CNAs provided the following care: The brief was removed, and the front of the resident's perineal area was cleansed, the resident was rolled from side to side, and stool was cleansed from the anal area and buttocks. A clean brief was applied. CNA #18 obtained clean pants from the resident's drawer and a clean shirt from the resident's closet, and the CNAs assisted the resident to dress. The CNAs placed a Hoyer lift sling under the resident, and handled the Hoyer lift controls to raise the resident from his bed and place him in a geri-chair, touching</p>						

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	<p>parts of the geri-chair in the process. The CNAs worked together to position the resident and attach leg straps used to help keep the resident from slipping from the chair. The resident's shoes were placed on his feet. The resident's chair was rolled toward the door. CNA #18 obtained the resident's glasses from his bedside table, entered the restroom with the resident's glasses, exited the restroom without gloves, donned clean gloves, and placed the glasses on the resident's face.</p> <p>The facility's policy related to "Hand Washing Technique" was provided by the Assistant Director of Nursing on 12/19/12 at 4:35 p.m. Review of the policy indicated, "Hands must be washed: ...After removal of gloves...." The "Disposable Non-Sterile Gloves" policy was provided at this same time. Review of the policy indicated, "...Change gloves and wash hand...between different body site procedures performed subsequently on the same resident (i.e. between g-tube [gastrostomy tube] dressing and Foley catheter care)."</p> <p>During the Exit Conference on 12/19/12 at 5:30 p.m., the DON indicated she coached CNA #4 when she noticed she was not following appropriate handwashing before leaving the room after removing gloves.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
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NAME OF PROVIDER OR SUPPLIER  JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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	3.1-18(I)			