

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/17/2012
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NAME OF PROVIDER OR SUPPLIER  ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: 1/9-13, 17/12</p> <p>Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360</p> <p>Survey Team: Laura Brashear RN TC Teresa Buske RN Mary Weyls RN Deb Skinner RN</p> <p>Census Bed Type SNF/NF: 36 Total: 36</p> <p>Census Payor Type: Medicare: 4 Medicaid: 17 Other: 15 Total: 36</p> <p>Stage 2 Sample: 29</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/23/12 by Suzanne</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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	Williams, RN			
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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure allegations of mistreatment were reported immediately to the Administrator, for 1 of 3 residents</p>	F0225	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions	02/16/2012	

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	<p>reviewed for investigations of abuse/neglect/mistreatment in a Stage 2 sample of 29. [Resident #14]</p> <p>Finding includes:</p> <p>During review of facility investigations of injuries of unknown source or allegation of mistreatment on 1/13/12 at 11:15 a.m., an allegation was noted of Resident #14 reporting to the Administrator on 11/7/11 of CNA #16 using foul language when providing personal care which makes her uncomfortable. The resident indicated the CNA was rude and disrespectful and indicated she was made to feel bad when requesting assistance.</p> <p>The CNA was suspended at that time, pending the investigation and later terminated for not following facility standards.</p> <p>Documentation regarding the investigation, provided by the Administrator on 1/13/12 at 11:15 a.m., included a written statement dated 11/7/11, from CNA #14, which included, but was not limited to: CNA #16 utilized foul language in front of the residents on all shifts. The CNA is rough with residents when transferring and doesn't seem to care. The CNA rushes with residents and doesn't provide the attention</p>		<p><b>set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-225 Staff Treatment of Residents (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> Resident #14 suffered no harm due to the allegations of abuse. Staff Member # 16 was terminated form employment. Staff Members # 14, 15, and 17 were re-educated on standards and guidelines for reporting, abuse and neglect immediately to the Facility Administrator and Director of Nursing. . <b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Resident interviews were conducted using the QIS Interview process to determine if they had any allegations of abuse or neglect that had not been reported and none were indicated. Staff were interviewed to determine if any allegations or suspicions of abuse or neglect had occurred and had not been reported timely to the Administrator and none were indicated <b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The</p>		

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	<p>they deserve.</p> <p>CNA #14 also indicated in the statement several residents had reported to her they did not want CNA #16 taking care of them.</p> <p>CNA #14 was interviewed on 1/13/12 at 1:00 p.m. The CNA indicated she had witnessed CNA #16 being rough with a resident. [Resident did not want to be identified] while maneuvering the resident in bed and the resident had indicated the CNA was "mean." CNA #14 indicated she thought the incident had occurred in October. The CNA indicated CNA #16 was just real rough. The CNA indicated Resident #14 expressed to her she did not want CNA #16 taking care of her. She indicated she had also heard Resident #46 tell the CNA to "get out" when she entered the room. CNA #14 indicated she had reported to the Administrator.</p> <p>A written report, provided by LPN #15 during the facility investigation, dated 11/7/11, indicated CNA #16 used foul language in front of residents and seemed to hurry through her work assignments at times. The LPN indicated he had only worked with the staff member a couple of times.</p>		<p>facility staff will be reeducated on standards and guidelines for reporting abuse and neglect immediately (within 24 hours) to the Administrator and Director of Nursing. The Facility Management Team will review event reports, grievances, 24 hour Reports, weekly skin checks, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any potential allegations of abuse and neglect and the need to report.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The Director of Social Services or designee will randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to ensure all allegations of abuse or neglect have been reported and the residents feel safe at the facility. The Facility Risk Manager will report results to the QA/Risk Management meeting and monthly thereafter with oversight of the RDCO Quarterly System review which includes Abuse /Neglect/Adverse event reporting.</p> <p><b>(e) Date of compliance:</b> 2/16/12</p>		

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	<p>LPN #15 was interviewed on 1/13/12 at 2:15 p.m. The LPN in addition to written statement provided felt CNA #16 acted like it was a burden to take care of the residents. The LPN indicated two residents, who he couldn't remember names of, indicated she made them feel rushed and like a bother when they asked for help. The staff member indicated he did not think he had reported this to anyone until the investigation on 11/7/11.</p> <p>A written statement provided by CNA #17 on 11/7/11 indicated CNA #16 was a little rough with some of the residents and does use the "F" word a lot in front of residents. The written statement indicated she would report it to the charge nurse on the shift who would talk to the CNA about it.</p> <p>The Administrator was interviewed on 1/13/12 at 11:40 a.m. The Administrator indicated she had not been made aware of the allegations until Resident #14 reported to her on 11/7/11 at which time CNA #16 was suspended and an investigation started.</p> <p>3.1-28(c)</p>			
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F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure allegations of mistreatment were reported immediately to the Administrator in accordance with the facility's policy for Abuse, Neglect, and Exploitation, for 1 of 3 residents reviewed for investigations of allegations of abuse/mistreatment/neglect in a Stage 2 sample of 29. [Resident #14]</p> <p>Finding includes:</p> <p>During review of facility investigations of injuries of unknown source or allegation of mistreatment on 1/13/12 at 11:15 a.m., an allegation was noted of Resident #14 reporting to the Administrator on 11/7/11 of CNA #16 using foul language when providing personal care which makes her uncomfortable. The resident indicated the CNA was rude and disrespectful and indicated she was made to feel bad when requesting assistance.</p> <p>The CNA was suspended at that time, pending the investigation and later terminated for not following facility standards.</p> <p>Documentation regarding the</p>	F0226	<p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-226 Practice and Guidelines regarding Abuse a. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>Resident #14 suffered no harm due to the allegations of abuse. Staff Member # 16 was terminated from employment. Staff Members # 14, 15, and 17 were re-educated on standards and guidelines for reporting, abuse and neglect immediately to the Facility Administrator and Director of Nursing.</p> <p><b>1.How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>Resident interviews were conducted using the QIS Interview process to determine if they had any allegations of abuse or neglect that had not been reported and none were</p>	02/16/2012			

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	<p>investigation, provided by the Administrator on 1/13/12 at 11:15 a.m., included a written statement dated 11/7/11, from CNA #14, which included, but was not limited to: CNA #16 utilized foul language in front of the residents on all shifts. The CNA is rough with residents when transferring and doesn't seem to care. The CNA rushes with residents and doesn't provide the attention they deserve.</p> <p>CNA #14 also indicated in the statement several residents had reported to her they did not want CNA #16 taking care of them.</p> <p>CNA #14 was interviewed on 1/13/12 at 1:00 p.m. The CNA indicated she had witnessed CNA #16 being rough with a resident. [Resident did not want to be identified] while maneuvering the resident in bed and the resident had indicated the CNA was "mean." CNA #14 indicated she thought the incident had occurred in October. The CNA indicated CNA #16 was just real rough. The CNA indicated Resident #14 expressed to her she did not want CNA #16 taking care of her. She indicated she had also heard Resident #46 tell the CNA to "get out" when she entered the room. CNA #14 indicated she had reported to the Administrator.</p>		<p>indicated. Staff were interviewed to determine if any allegations or suspicions of abuse or neglect had occurred and had not been reported timely to the Administrator and none were indicated</p> <p><b>1.What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The facility staff will be reeducated on standards and guidelines for reporting abuse and neglect immediately (within 24 hours) to the Administrator and Director of Nursing. The Facility Management Team will review event reports, grievances, 24 hour Reports, weekly skin checks, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any potential allegations of abuse and neglect and the need to report.</p> <p><b>1.How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The Director of Social Services or designee will randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to ensure all allegations of abuse or neglect have been reported and the residents feel safe at the facility. The Facility Risk Manager will report results to the QA/Risk Management meeting and monthly thereafter with</p>				

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	<p>A written report, provided by LPN #15 during the facility investigation, dated 11/7/11, indicated CNA #16 used foul language in front of residents and seemed to hurry through her work assignments at times. The LPN indicated he had only worked with the staff member a couple of times.</p> <p>LPN #15 was interviewed on 1/13/12 at 2:15 p.m. The LPN in addition to written statement provided felt CNA #16 acted like it was a burden to take care of the residents. The LPN indicated two residents, who he couldn't remember names of, indicated she made them feel rushed and like a bother when they asked for help. The staff member indicated he did not think he had reported this to anyone until the investigation on 11/7/11.</p> <p>A written statement provided by CNA #17 on 11/7/11 indicated CNA #16 was a little rough with some of the residents and does use the "F" word a lot in front of residents. The written statement indicated she would report it to the charge nurse on the shift who would talk to the CNA about it.</p> <p>The Administrator was interviewed on 1/13/12 at 11:40 a.m. The Administrator indicated she had not been made aware of</p>		oversight of the RDCO Quarterly System review which includes Abuse /Neglect/Adverse event reporting. <b>Date of compliance: 2/16/12</b>				

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	<p>the allegations until Resident #14 reported to her on 11/7/11 at which time CNA #16 was suspended and an investigation started.</p> <p>The facility's policy titled "Abuse, Neglect, and Exploitation," dated 11/03, provided by the Administrator on, 1/12/12 at 1:40 p.m., included, but was not limited to, "4. Identification: When any allegation...occurs, The Administrator and Director of Nursing will be notified immediately. Staff members involved will be suspended from work pending investigation. 6. Protection: The facility will protect residents from harm during an investigation up to and including putting suspected employees on suspension pending investigation."</p> <p>3.1-28(a)</p>						

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F0278 SS=D	<p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure each Minimum Data Set (MDS) assessment accurately reflected each resident's status for the use of antipsychotics for 1 of 29 residents reviewed for assessments in the stage 2 sample of 29. [Resident # 12].</p> <p>Finding includes:</p> <p>Review of the clinical record of Resident</p>	F0278	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p><b>F 278</b> (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #12 MDS was modified to</p>	02/16/2012
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	<p>#12 on 1/12/12 at 11 a.m. indicated a current physician's order dated 11/1/11, for perphenazine (antipsychotic) 4 milligram three times daily and perphenazine 2 milligram at bedtime. Discontinued physician orders were noted dated 8/8/11, for perphenazine 4 milligram five times daily and perphenazine 4 milligram four times daily dated 9/20/11.</p> <p>Minimum Data Set (MDS) assessments dated 8/15/11 admission assessment, 12/28/11 quarterly assessment, and 11/17/11 significant change assessment did not identify the use of antipsychotics.</p> <p>Interview of the Director of Nursing and the MDS coordinator/RN #12 on 1/13/12 at 2:30 p.m. indicated the antipsychotic was not reflected on the MDS assessments due to the resident being in the perphenazine due to neurological needs. The DON indicated the perphenazine had been increased after a decrease due to the resident having an increase in delusions. The DON indicated the antipsychotic should have been reflected on the Minimum Data Set (MDS) assessments.</p> <p>3.1-31(d)</p>		<p>accurately reflect the antipsychotic use.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Residents receiving antipsychotic classification medications will have their last MDS reviewed for accuracy of coding. Any Resident receiving antipsychotic medication will have their MDS accurately reflected.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The IDT will be educated regarding the coding of medications on the MDS by classification versus indication.</p> <p><b>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The monitoring of this will be a joint effort between the DNS and MDS coordinator who will review 5 charts per week for the next four weeks and then bi-weekly for 2 months to ensure accurate coding of medication classification. Report of these findings will be presented at the next Risk Management/QA Committee Meeting to determine compliance and the committee recommends quarterly oversight by the regional director of UR when doing facility review(s) which includes accurate coding of medication classification.</p> <p><b>(d) Date of compliance:</b> Feb 16, 2012</p>		

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation and record review, the facility failed to assess and initiate a plan of care for a resident with bony abnormalities which predisposed the resident for development of a pressure ulcer. This deficient practice affected 1 of 2 residents reviewed for pressure ulcers of 2 who met the criteria for pressure ulcers in the stage II sample of 29. [Resident #23].</p> <p>Finding includes:</p> <p>Resident #23's clinical record was reviewed on 1/12/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease</p>	F0279	<p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F279 (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> Resident #23 care plan was updated to accurately reflect current skin conditions, risk factors, and interventions <b>(b) How you will identify other residents having potential to</b></p>	02/16/2012	

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	<p>with grafts, Parkinson's disease, dysphagia due to stroke, peripheral vascular disease (PVD), and skin cancer to the scalp.</p> <p>An Admission Nursing Assessment dated 6/12/11, indicated the resident had a reddened coccyx and wounds to the scalp from radiation d/t [due to] melanoma. The Braden assessment attached to the document indicated the resident was at moderate risk (score of 14) for the development of pressure ulcers.</p> <p>Review on 1/18/12 at 3 p.m., of a Care Area Assessment Pressure Ulcer Worksheet dated 6/19/11, indicated the resident had an existing pressure ulcer (location not indicated); Under "Extrinsic risk factors" no boxes were checked (These risk factors would have included level of dependence for bed/chair mobility [resident was totally dependent for all activities of daily life] and need for turning/repositioning, and special padding/mattress); "Intrinsic risk factors": Only altered mental status was indicated (Immobility, incontinence and poor nutrition were not checked, and the resident had all of these risk factors); Under "Diagnoses and conditions that present complications or increase risk for pressure ulcers" the boxes of "Cancer, PVD, Other dementia" had been checked.</p>		<p><b>be affected by the same practice and what corrective action will be taken:</b> Residents with pressure ulcer risk factors will have their care plans reviewed to ensure that current skin conditions, risk factors, and interventions are present and reflective of the resident. Any resident found to be lacking a Risk for Impaired Skin Integrity care plan when indicated by risk factors will be assessed for a Significant Change in Status Assessment. <b>(c) What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur:</b></p> <ul style="list-style-type: none"> <li>·The IDT will be in serviced on CAA and care plan development per the RAI Manual, Appendix C.</li> <li>·Resident status changes will be reviewed during the morning meeting daily and any newly identified skin risk factors will prompt a care plan review.</li> <li>·The resident will be assessed quarterly and with condition change utilizing the Braden Scale to additionally identify new or additional skin risk factors.</li> </ul> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The DNS or designee will audit 3 MDS per week X 12 weeks to ensure accurate coding of medication classification.</p>	
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	<p>No other conditions were included as risk factors for the development of pressure ulcers. Under "Analysis of Findings" was "Kyphosis, Dementia, Parkinson's". Under "Care Plan Considerations" was "Proceed to care plan. At this time...is free from red or open areas. She does require assist with her mobility and transfers. She is incontinent at times. Nursing will continue to assist her with her mobility and turning. Nursing will assess her weekly during showers for s/s (signs and symptoms) skin breakdown..."</p> <p>A plan of care to address the resident being at risk for the development of pressure ulcers due to the bony foot deformities the resident had presented with upon admission was lacking.</p> <p>A Podiatrist progress note dated 9/28/11 documented: "...Examined...today for a follow-up visit at the request of the SSD (social service director)...Today's visit is for the Presenting Problem/Chief Complaint of Nails Long on both feet, Nails Thick on feet...I also noted: wound 4th toe Right foot... PVD (peripheral vascular disease)...Dermatological exam: positive for findings of: Absent hair growth on both feet, decreased elasticity on both feet, Decreased Turgor on both feet, Edema Moderate on both feet and Thin Skin on both feet...Ulcers: Ulcer #</p>		<p>Any MDS found to be inaccurately coded will be modified to reflect accuracy..</p> <p>Report of these audits will be discussed at the monthly QA/Risk Management with oversight by the RDCO when completing the Quarterly systems review including MDS/Care Plans..</p> <p>(e) <b>Date of compliance:</b> Feb 16, 2012</p>	

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	<p>1: initial wound assessment: size ...1 x 0.6 x 0.2 cm on right toe 4 lateral. The ulcer has a stable eschar to depth of a bone with infection and reduced circulation. There is redness within 4 cm of wound. There is no induration within 4 cm of wound...The ulcer is a stage IV wound...Localized erythema and edema of 4th right foot, no streaking, no necrosis, positive malodor...Musculoskeletal: ...Hammer toe deformities noted at right toe 2, 3, 4 and 5...Deformity noted at right foot is a Tailor's Bunion and Hallux Valgus...Range of motion was rigid on right...Procedures &amp; Plan: ..Ulcer reference #1 is Stage IV right toe lateral. ...debrided ...Keflex [antibiotic] 250 mg po qid x 14 days. Cleanse wound 4th toe rt ft [foot] with NS then apply dry gauze dly until healed..."</p> <p>Documentation on a form titled "Wound Progress Record" was noted of a wound to the right 4th toe was found on 9/28/11. The documentation indicated the area was a Stage IV pressure with measurement of 0.7 cm [centimeters] x 0.7 cm x &lt;0.1 cm (with a depth of less than 0.1 cm) with this area having been indicated as having evolved due to pressure of the resident's toes resting upon one another due to the bony deformities the resident had.</p> <p>An Interdisciplinary Plan of Care (IPOC)</p>			
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	<p>Summary dated 9/29/11, indicated "4th toe right foot noted by podiatrist. Physician's order ATB [antibiotic] tx (treatment) Stage IV according to Podiatrist."</p> <p>The resident's plan of care dated 10/3/11, addressed the problem of resident has pressure ulcer Stage IV on right toe related to immobility, overlapping toes and impaired circulation</p> <p>The podiatrist progress note dated 11/29/11 was noted of: "Follow up visit: ...Ulcers: Ulcer number 1 is a pressure ulcer... positive for diminishing area &amp; depth...wound status is stable...no edema...no erythema...no malodor...Procedures &amp; Plan: ...debrided...using a curette and tissue nipper...Infection has completely resolved, symptoms are improving and wound is stable. Don't expect the wound to heal in an expeditious rate due to pt's poor circulation with possibility that wound may not heal due to poor circulation...."</p> <p>The resident was observed on 1/12/12 at 11 a.m. LPN #5 performed a treatment to the resident's right 4th toe. LPN #5 removed a dressing, cleansed the area with normal saline and applied Polysporin powder. The LPN then applied a dry</p>				

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	<p>gauze between the toes. The resident's 4th toe of the right foot was observed to have a scabbed area along the inside surface of the toe where it rested upon the fifth toe.</p> <p>A policy/procedure dated, April 2007, and titled "Pressure Ulcers/Skin Breakdown-Clinical Record" provided by the DON, on 1/12/12 at 11 a.m., included, but not limited to, "Assessment and Recognition: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s)...Cause Identification: 1. the physician will help identify factors contributing or predisposing residents to skin breakdown..."</p> <p>3.1-35(a)</p>			
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F0314 SS=G	<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, record review, and interview, the facility failed to assess and plan care for a resident with bony abnormalities which predisposed the resident for development of a pressure ulcer which was not found until the area was a stage IV. This deficient practice affected 1 of 2 residents reviewed for pressure ulcers of 2 who met the criteria for pressure ulcers in the stage II sample of 29. Resident #23.</p> <p>Finding includes:</p> <p>Resident #23's clinical record was reviewed on 1/12/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease with grafts, Parkinson's disease, dysphagia due to stroke, peripheral vascular disease (PVD), and skin cancer to the scalp.</p> <p>An Admission Nursing Assessment dated 6/12/11, indicated the resident had a reddened coccyx and wounds to the scalp</p>	F0314	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. <b>F-314 Pressure Ulcers (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> Identified skin area to resident #23 was re-assessed, wound was measured and documented. Physician was notified and treatment orders remain in place. Care plan was reviewed. <b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> A facility wide "Skin Sweep" was completed on the active to observe for pressure ulcers and to assure that any pressure ulcers identified were correctly measured , appropriate treatments were implemented,</p>	02/16/2012			

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	<p>from radiation d/t [due to] melanoma. The Braden assessment attached to the document indicated the resident was at moderate risk (score of 14) for the development of pressure ulcers.</p> <p>Review on 1/18/12 at 3 p.m., of a Care Area Assessment Pressure Ulcer Worksheet dated 6/19/11, indicated the resident had an existing pressure ulcer (location not indicated); Under "Extrinsic risk factors" no boxes were checked (These risk factors would have included level of dependence for bed/chair mobility [resident was totally dependent for all activities of daily life] and need for turning/repositioning, and special padding/mattress); "Intrinsic risk factors": Only altered mental status was indicated (Immobility, incontinence and poor nutrition were not checked, and the resident had all of these risk factors); Under "Diagnoses and conditions that present complications or increase risk for pressure ulcers" the boxes of "Cancer, PVD, Other dementia" had been checked. No other conditions were included as risk factors for the development of pressure ulcers. Under "Analysis of Findings" was "Kyphosis, Dementia, Parkinson's". Under "Care Plan Considerations" was "Proceed to care plan. At this time...is free from red or open areas. She does require assist with her mobility and</p>		<p>and documented accordingly. Care plans reviewed and revised as needed. No new areas were identified during the sweep. (c) <b>What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> Nursing Staff have been re-educated on the components of F-314 regarding prevention of pressure areas and pressure reducing measures with a focus on turning and repositioning, off loading tissue management, and reporting to the licensed nurse any change in a resident's skin condition. Additionally licensed nurses were educated on the facility's wound care program with a focus on those residents assessed to be at high risk for skin breakdown. DNS or Designee will observe turning and repositioning as well as identifying that pressure relieving devices are in place during daily facility rounds. (d) <b>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The facility DNS or designee will conduct a random weekly audit of at least 4 residents per week x 4 weeks and then every 2 weeks X 2 months to ensure that the residents have pressure ulcer prevention interventions implemented when</p>		

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	<p>transfers. She is incontinent at times. Nursing will continue to assist her with her mobility and turning. Nursing will assess her weekly during showers for s/s (signs and symptoms) skin breakdown..."</p> <p>The January 2012 physician's recapitulation of orders were noted of: " Low air loss (LAL) mattress (07/19/11); monitor heels for off loading (07/20/11); Broda chair for comfort and positioning (08/14/11); Bacitracin 500 units/gram ointment apply cleansing with NS (normal saline) to right foot fourth toe with dry gauze. Change daily until healed (09/28/11); Polysporin powder apply topically between toes daily (12/04/11); Remeron [anti-depressant] 15 mg (milligrams) po (by mouth) daily at HS (hour of sleep) [08/16/11]; Resource Arginaid [dietary supplement] 1 pkt (packet) in water po bid (12/01/11); and Thera-M tablet [dietary supplement]one po daily (08/16/11)."</p> <p>Physician's telephone orders were noted dated 9/28/11, for Keflex [antibiotic] 250 mg [milligrams] po qid (four time daily) times 14 days, cleanse wound on 4th toe right foot with NS then apply Bacitracin with dry gauze daily until healed.</p> <p>A document titled 'Weight record' was noted of an admission weight dated</p>		<p>assessed at Moderate or High Risk according to their most recent Braden Scale score. Additionally, the audit will be used to ensure wound care is performed and documented in accordance to the physician's order. Any issues identified will be immediately corrected and staff re-educated.</p> <p>Report of the findings will be reported at the monthly Risk Management/QA meeting, with oversight by the RDCO when completing the quarterly system review which includes review of wound and skin care.</p> <p><b>(e) Date of compliance: 2-16-12</b></p>		

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	<p>6/15/11 of 109.7 lbs (pounds). A 1/4/12 weight was documented of 105.8 lbs.</p> <p>Physician's progress notes were noted on 9/04/11 of "...Open area coccyx...albumin 3.5..."[normal value 3.5-5.0]. A progress note on 10/02/11 documented: "Pt [patient] has confirmed wt [weight] decline. Wt does go up &amp; down... HGB 11.5 [hemoglobin normal value 11.7-13.8] ..Cre [Creatinine] 0.7... [normal value 0.5-1.5]." (This entry did not address the resident's stage IV pressure area found on 09/28/11).</p> <p>Podiatrist progress notes were noted of: 09/28/11: "...Examined...today for a follow-up visit at the request of the SSD (social service director)...Today's visit is for the Presenting Problem/Chief Complaint of Nails Long on both feet, Nails Thick on feet...I also noted: wound 4th toe Right foot... PVD (peripheral vascular disease)...Dermatological exam: positive for findings of: Absent hair growth on both feet, decreased elasticity on both feet, Decreased Turgor on both feet, Edema Moderate on both feet and Thin Skin on both feet...Ulcers: Ulcer # 1: initial wound assessment: size ...1 x 0.6 x 0.2 cm on right toe 4 lateral. The ulcer has a stable eschar to depth of a bone with infection and reduced circulation. There is redness within 4 cm</p>						

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	<p>of wound. There is no induration within 4 cm of wound...The ulcer is a stage IV wound...Localized erythema and edema of 4th right foot, no streaking, no necrosis, positive malodor...Musculoskeletal: ...Hammer toe deformities noted at right toe 2, 3, 4 and 5...Deformity noted at right foot is a Tailor's Bunion and Hallux Valgus...Range of motion was rigid on right...Procedures &amp; Plan: ..Ulcer reference #1 is Stage IV right toe lateral. ...debrided ...Keflex 250 mg po qid x 14 days. Cleanse wound 4th toe rt ft [foot] with NS then apply dry gauze dly until healed..."</p> <p>A physician's progress note dated 11/02/11 was noted of: "...Open area 4th toe...BMP [blood metabolic profile] and BUN [blood urea nitrogen...]"</p> <p>The podiatrist progress note dated 11/29/11 was noted of: "Follow up visit: ...Ulcers: Ulcer number 1 is a pressure ulcer... positive for diminishing area &amp; depth...wound status is stable...no edema...no erythema...no malodor...Procedures &amp; Plan: ...debrided...using a curette and tissue nipper...Infection has completely resolved, symptoms are improving and wound is stable. Don't expect the wound to heal in an expeditious rate due to pt's poor circulation with possibility that</p>			
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	<p>wound may not heal due to poor circulation...."</p> <p>On 12/04/11 the physician's progress note documented: "Pt has pressure area between 4th &amp; (and) 5th toes on right foot...Labs are fairly good..."</p> <p>No Doppler studies were found to indicate the resident had been tested for the severity of the PVD. Interview on 1/12/12 at 3 p.m., with LPN #12 indicated the resident's daughter had not wished for the resident to be put through this kind of testing d/t [due to] her weakened condition.</p> <p>The resident was observed on 1/12/12 at 11 a.m. LPN #5 performed a treatment to the resident's right 4th toe. LPN #5 removed a dressing, cleansed the area with normal saline and applied Polysporin powder. The LPN then applied a dry gauze between the toes. The resident's 4th toe of the right foot was observed to have a scabbed area along the inside surface of the toe where it rested upon the fifth toe.</p> <p>Documentation on a document titled "Wound Progress Record" was noted of a wound to the right 4th toe was found on 9/28/11. The documentation indicated the area was a Stage IV pressure with</p>			
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	<p>measurement of 0.7 cm [centimeters] x 0.7 cm x &lt;0.1 cm (with a depth of less than 0.1 cm) with this area having been indicated as having evolved due to pressure of the resident's toes resting upon one another due to the bony deformities the resident had.</p> <p>Wound measurement dated 1/05/12 on the record was noted of: Stage IV with measurement of 0.4 cm x 0.5 cm x &lt; 0 presenting as a scabbed area.</p> <p>Lab values documented in the resident's clinical record were noted of: 1/04/12: Chlorine 110 (High), glucose 159 (High), BUN (Blood urea nitrogen) 34 (High), GFR (glomerular filtration rate) 59 (Low), HCT (Hematocrit) 35.2 (Low).</p> <p>9/07/11: RBC (Red blood count) 3.73 (Low), HGB (Hemoglobin) 32.8 (Low), BMP (Basic metabolic profile) no abnormal.</p> <p>Documentation in the Dietary progress notes were noted, dated 8/10/11, of the resident's family refused for resident to have a feeding tube despite weight loss due to poor oral intake.</p> <p>A 10/19/11 dietary progress note did not address the new stage IV area to the resident's right 4th toe.</p>			
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	<p>On 11/03/11 the dietary progress note indicated the resident had a "new" stage IV area to the right 4th toe.</p> <p>The 12/01/11 dietary note indicated the resident continued to have a stage IV area to the right 4th toe.</p> <p>A 12/08/11 dietary note documented the resident's diet was upgraded to regular and it was reiterated the family still did not want a feeding tube.</p> <p>The resident's plan of care, dated 10/3/11, addressed the problem of resident has pressure ulcer Stage IV on right toe related to immobility, overlapping toes and impaired circulation.</p> <p>An Interdisciplinary Plan of Care (IPOC) Summary dated, 9/29/11, indicated "4th toe right foot noted by podiatrist. Physician's order ATB [antibiotic] tx (treatment) Stage IV according to Podiatrist."</p> <p>A plan of care to address the resident being at risk for the development of pressure ulcers due to the bony foot deformities the resident had presented with upon admission was lacking.</p> <p>A Braden risk assessment dated 07/04/11</p>			
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	<p>indicated a score of 14 or moderate risk.</p> <p>A Braden risk assessment dated 11/09/11, indicated a score of 9 which indicated severe risk.</p> <p>LPN #5 was interviewed on 1/13/12 at 11:30 a.m. The LPN indicated no new Braden risk assessment had been done after the Stage IV area to the resident's 4th right toe had developed, and further indicated she was unaware of any facility policy to do a new Braden risk assessment in this situation.</p> <p>The MAR [Medication Administration Record] for September 2011, indicated the resident's skin had been assessed on a weekly basis as ordered by the physician on 8/23/11 by the nurse on 9/10/11, 9/17/11, and 9/24/11. Documentation of the assessment being completed on 9/2/11 and 9/30/11 was lacking.</p> <p>The MAR for September 2011 indicated the resident "may receive shower and skin assessment M, W, F (Monday, Wednesday, Friday)." No problems had been documented by the nurse regarding any problems which had been found by the CNA' when they had conducted shower/skin assessments 3 times per week (This order was dated 08/23/11).</p>			
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	<p>A document titled "CNA Weekly Bath and Skin Report" for the month of September 2011, documented on 9/23/11, by CNA #9 reported an open area on the resident's second little toe [resident's fourth toe] to LPN #5.</p> <p>LPN #5 was interviewed on 1/17/12 at 3:00 p.m. The LPN indicated she had been made aware of the area on 9/23/11, assessed it, but was unable to find any documentation of the area.</p> <p>A Nurse's Note dated 9/29/11, indicated "Late entry 09/28/11 approx (approximately) 3:00 p.m.: Podiatrist requested for nurse to see the 4th toe rt (right) foot with him...Progress note present in chart..." No other documentation was found in the Nurse's Notes regarding discovery of the stage IV pressure ulcer to the resident's right 4th toe.</p> <p>An Interdisciplinary Plan of Care (IPOC) Summary dated 9/29/11, indicated "4th toe right foot noted by Podiatrist. P.O. (Physician's Order) ATB (Antibiotic) Tx (Treatment) Stage IV according to Podiatrist..."</p> <p>A policy/procedure dated, April 2007, and titled "Pressure Ulcers/Skin Breakdown-Clinical Record" provided by</p>			
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	<p>the DON on, 1/12/12 at 11 a.m. included, but not limited to, "Assessment and Recognition: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s)...Cause Identification: 1. the physician will help identify factors contributing or predisposing residents to skin breakdown..."</p> <p>3.1-40(a)(1)</p>			
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F0387 SS=D	<p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview the facility failed to ensure each resident was seen by a physician at least once every 30 days for the first 90 days after admission for 1 of 5 stage 2 residents reviewed requiring every 30 day physician visits in a stage 2 sample of 29. (Resident # 46).</p> <p>Finding includes:</p> <p>Review of the clinical record of Resident #46 on 2/13/12 at 2:05 p.m. indicated the resident was admitted on 9/18/11. Documentation was noted of physician visits on 9/19/11, 10/27/11, and 1/9/12. Documentation of a physician visit in November 2011 was lacking.</p> <p>Interview of the Director of Nursing on 1/17/12 at 12:30 p.m. indicated the resident should have been seen every 30 days for the first 90 days after admission and that the physician had not seen the resident every 30 days.</p> <p>Interview of the MDS Coordinator/Medical Records RN #12</p>	F0387	<p><b>F 387 Physician Visits</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> Resident # 46 Physician was immediately called/notified regarding the requirement to see new admissions at least once every 30 days for the first 90 days after their admission, and more often if needed. The physician(s) has since completed a visual review of the above resident and documented this visit note under the physician progress record of the chart.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Active resident records were reviewed for physician visits. Any chart that showed no physician visit in the last 30 days for new admission within their 90-day period had their MD contacted for required compliance.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> ·Medical records designee will track the due dates for physician visits and notify physicians by letter, phone, and/or fax of resident's visit due dates. The Medical records designee will notify the DNS of regulatory compliance issues related to physician's visits. ·Nurse's reviewing the monthly POS</p>	02/16/2012	

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	<p>indicated the resident should have been seen every 30 days and that the resident had not been seen in November 2011. The RN indicated she had notified the physician that the resident was required to be seen.</p> <p>Review of the facility's current policy and procedure titled "Physician Visits" dated 4/2008 on 1/17/12 at 1:53 p.m. indicated "...1. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter...."</p> <p>3.1-22(d)(1)</p>		<p>change-over process will review progress notes for physician visit compliance and notify the DNS of regulatory compliance issues related to physician's visits.</p> <p>-The MDSC will review progress notes during the completion of MDS assessments and notify the DNS regulatory compliance issues related to physician's visits.</p> <p>-Physician's found during the above auditing and review process to be out of regulatory compliance with physician's visits will receive a phone call by the DNS or designee requesting an onsite visit and written progress note to occur as soon as reasonably possible.</p> <p>-If a physician is determined to be unable to meet regulatory requirements for physician's visits, the Medical Director will be notified and a suitable alternative developed.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> This will be a joint effort between the MDS Coordinator and the DNS/designee who will randomly monitor 5 charts weekly for the next 4 weeks and then bi-monthly thereafter to identify any non-compliance of physician visits for immediate corrective action. Report of these audits will be discussed at the monthly QA/Risk Management to determine when compliance has been achieved and the committee recommends that quarterly monitoring by the RDCO to maintain compliance.</p> <p><b>(e) Date of compliance: 2/16/2012</b></p>		

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to implement measures including personal protective equipment, linen bags</p>	F0441	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions	02/16/2012			

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	<p>identifying contents as isolation, and appropriate concentration of surface cleaning solutions effective to prevent transmission of clostridium difficile [c-difficile], for 2 of 2 residents in a stage II sample of 29 reviewed with positive infections for c-difficile. [Residents #12 and #50]</p> <p>Findings include:</p> <p>1. On 1/11/12 at 11:30 a.m. the DON was interviewed. The DON indicated two residents, Residents #50 and #12, residing in the facility, were positive for C-difficile infections. The DON indicated Resident #50 and #12 utilize bed side commodes in their rooms.</p> <p>Resident #50 was interviewed on 1/10/12 at 10:30 a.m. No signage was observed alerting visitors to check with nurse prior to entering room, no personal protective equipment other than clean gloves were observed in the room. The resident's room did not include a bathroom or have a hand sink in the room.</p> <p>On 1/11/12 at 10:30 a.m., CNAs #2 and #6 were observed entering the soiled utility room after exiting Resident #50's room. CNA #6 was not wearing gloves and was observed carrying a urinal containing urine. The CNAs were</p>		<p><b>set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F- 441 Infection Control (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Issue #1: Signs were placed on doors for residents # 50 and #12 alerting staff and visitors to check with nurse before entering room. Issue #2: Personal protective equipment, gowns, gloves, red bags were placed in rooms of residents #50 and #12 who tested positive for c-diff. Issue #3: Teachable moment was provided to C N A # 6 , # 2 and #10 on use of personal protection equipment gloves, when disposing of body fluids and linens and cleaning of soiled or contaminated items. Issue #4: Educated staff on proper documentation of description of bowel movements on the bowel movement record. Issue #5: Plan of care for resident #12 reviewed and updated to include contact precautions to prevent spread of Clostridium Difficile. Resident # 50 no longer resides in facility. Issue #6: Teachable moment to Housekeeper # 13 on proper solution and dilution of</b></p>				

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	<p>interviewed regarding Resident #50. The staff members indicated they do not utilize any personal protective equipment other than gloves when caring for the resident and indicated the resident utilizes a bed side commode which is emptied in the hopper in the soiled utility room. CNA #2 indicated the resident was having loose stools the previous day.</p> <p>Resident #50's clinical record was reviewed on 1/17/12 at 2:00 p.m. An admission date was noted of 1/4/12 from the hospital. The resident was receiving intravenous antibiotics for cellulitis and abscess of leg aseptic necrosis.</p> <p>An initial nursing assessment, completed on 1/4/12 checkmarked on the form the resident had diarrhea and was receiving antibiotics.</p> <p>A physician's order was noted dated 1/7/12 for liquid stool check for c-difficile. Pepto Bismol tabs every am and pm for liquid stools.</p> <p>Documentation on the resident's medication administration record reviewed on 1/17/12 at 2:00 p.m. included, but was not limited to the resident receiving Pepto-Bismol four tablets at 8: a.m. on 1/10, 11, 12, 13, and 14/12 and at 8:00 p.m. on 1/11, 12, and</p>		<p><b>cleaning products (use of hypochloride solution) and the proper protective equipment when cleaning bathrooms of Residents with Clostridium Difficile. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility round was completed by DNS to observe staff practices and no other residents were found to have symptoms requiring contact isolation. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Residents presenting with 3 or more loose stools in a shift shall have their MD notified review of current signs and symptoms for possible orders and to determine if precautions should be instituted. Re-education of staff on infection control specific to contact precautions was held on 1/26/12 that included use of personal protection equipment, red bag use for linen and cleaning techniques to include proper solutions and dilutions to prevent spread of clostridium difficile. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e.,</b></p>		

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	<p>13/12.</p> <p>Documentation on the record of the resident's bowel movements was noted of: extra large and medium on 1/5; medium and large on 1/6; medium, extra large and small on 1/7; large, small and medium on 1/8; extra extra large, large and large on 1/9; large, extra large, and large on 1/10; medium and large on 1/11; extra large, medium and small on 1/12, and extra large times six and small on 1/13/12. A description of the bowel movements in the clinical record was lacking.</p> <p>A nursing note dated, 1/9/12 at 1:40 a.m., documented the resident's temperature of 101.4 degrees Fahrenheit. A nursing note dated 1/9/12 at 3:05 p.m. included, but was not limited to, "States doesn't feel well today. ...complained of diarrhea. Stool sample sent for c-diff."</p> <p>A nursing note dated 1/7/12 at 6:20 p.m. was noted of "Dr. [name] here this pm et [and] examined res. ...n.o. [new order] rec'd [received] for stool for c-diff; Pepto-Bismol 4 tabs po [by mouth] every am and pm ..."</p> <p>A laboratory report dated 1/9/12 was noted of c-difficile antigen-positive. C-difficile Toxin A and B-positive. Positive toxigenic strain of c-difficile</p>		<p><b>what quality assurance program will be put into place:</b>  <b>DNS/Designee will provide direct observation and audit staff twice weekly for four weeks then weekly for four weeks for practices regarding contact isolation, linen handling, body fluid disposal and housekeeping practices of dilution and solution type for cleaning, and use of personal protection equipment. Any issues identified will be immediately corrected with staff re education. Report of audit findings will be reviewed by the Risk Management/QA meeting with oversight by RDCO when completing Quarter Systems review including infection control.</b>  <b>(e) Date of compliance:</b>  <b>2/16/12</b></p>		

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	<p>identified. Communicability of disease is high if diarrhea is present.</p> <p>A physician's order was noted dated 1/10/12 for Vancomycin 250 mg po qid and 10 days for c-diff. Questran po qid ...label hand sanitizer gel not for c-diff.</p> <p>A plan of care was noted dated 1/10/12, for Bowel Elimination Problem diarrhea related to infection d-diff. Approaches included, but were not limited to...Instruct resident in good clean hygiene techniques to avoid cross-contamination, wash hands frequently and especially after bowel movements. A plan of care to address any special precautions to prevent transmission of infectious agents was lacking.</p> <p>Documentation on the nursing note dated 1/7/12 indicated the resident required assistance of one for activities of daily living and assistance of two for transfers.</p> <p>Housekeeper #3 was interviewed on 1/12/12 at 11:10 a.m. The housekeeper indicated residents who are in isolation have linens bagged in red bags. The housekeeper indicated she knows to wear protective apron as well as gloves when washing the linens and they are laundered separately from other linens. The housekeeper indicated she utilizes strong</p>			
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	<p>bleach in all loads of laundry.</p> <p>Interview of Housekeeper #8 on 1/13/12 at 10:30 a.m., indicated 2 ounces of Cavicide-surface disinfectant is used to one gallon of water to clean floors of rooms where residents in isolation reside. The housekeeper indicated the product is utilized full strength in spray bottle to clean touch surfaces. The Housekeeper indicated she had been informed the morning of 1/13/12 not to dilute the Cavicide product.</p> <p>Manufacturer's product information provided by the DON on 1/12/12 at 11:00 a.m., indicated the product was a surface disinfectant. The information included, but was not limited to "Cavicide has biocidal effectiveness against the following microorganisms: Clostridium difficile (vegetative cells only)." The information also indicated a three minute contact time is required as indicated on the product label. Documentation on the bottle of the product, identified by Housekeeper #8 as the bottle being diluted for floor cleaning, was noted of "Ready to use." Information regarding dilution of the product was lacking.</p> <p>2. During initial tour on 1/9/12 at 11:15 a.m., the Director of Nursing indicated two residents were being tested for Clostridium Difficile.</p>			
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	<p>On 1/10/12 at 10:45 a.m., Resident #12's room was observed and postings indicating any type of isolation was lacking. Isolation items such as disposable gowns, red bags, etc. were not present in the resident's room.</p> <p>Interview of the DON on 1/10/12 at 11:30 a.m. indicated Resident #12 was not in contact isolation for the Clostridium Difficile due to the resident not having loose stools.</p> <p>On 1/12/12 at 10:21 a.m. , Resident #12 was observed to be toileted in the bathroom by CNA # 10. The resident was observed to refuse to use the bedside commode in the resident's room. The CNA was observed to assist the resident to sit on the toilet. The CNA provided the resident with call light and instructed to call when done. The CNA then exited the bathroom after washing hands. The CNA proceeded to the resident's room and removed a cloth incontinent pad from the recliner seat (the resident had been sitting in the recliner prior to toileting). The cloth incontinent pad was observed with brown stains in the pad. The CNA bagged the soiled linen in a clear plastic bag and placed the bag in the laundry room barrel with other soiled linens.</p>			
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	<p>Interview of CNA #10 on 1/12/12 at 11 a.m., indicated the CNAs had not been told Resident #12 was in isolation even though he had "C. Diff." The CNA indicated that if the resident was in isolation, signs would be posted alerting the staff and families of the isolation. The CNA also indicated they would have to wear gowns, barrels placed in rooms, and use red bags for all the resident's linens. CNA #10 indicated the resident had diarrhea stools and that she does not wear gowns with Resident #12. It is the CNA's discretion to wear gowns.</p> <p>At 11:05 am. on 1/12/12, CNA #10 was observed to reenter the bathroom due to Resident #12 turning on the call light. The CNA with gloves on, was observed to provide pericare to the resident. The resident's brief was noted to have loose bowel movement in the brief. The CNA was observed not to wear a disposable gown. The CNA and resident were observed to wash hands prior to exiting the bathroom. The CNA was observed to bag the resident's soiled clothing and trash separate clear plastic bags. The soiled laundry was observed to be placed into the soiled linen barrel with other residents' soiled linens. The CNA was observed to secure the bathroom and inform the housekeeper for the bathroom to be cleaned.</p>			
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	<p>Interview of housekeeper # 13 on 1/12/12 at 11:10 a.m. indicated the disinfectant "Cavicide" was used to clean the bathroom and that she allowed the disinfectant to remain on the surfaces for at least 3-4 minutes. The housekeeper also indicated "Clorox" bleach spray was used to clean the bathroom.</p> <p>Housekeeper #13 was observed not to wear a disposable gown while cleaning the bathroom after Resident #12 had utilized on 1/12/12 at 11:10 a.m.</p> <p>Review of the clinical record on 1/12/12 at 11 a.m. indicated the resident was positive for Clostridium Difficile on 11/7/11 and 1/9/12.</p> <p>On 1/13/12 at 9:45 a.m., a sign was noted posted on Resident #12's door indicating to report to the nurse before entering the resident's room. Isolation supplies were observed available in Resident #12's room, i.e. red bags, and disposable gowns.</p> <p>On 1/17/12 at 12:30 p.m. the Administrator provided inservice materials provided to the staff on 11-3-11, concerning C-diff. Documentation concerning the cleansing of the environment was not noted.</p> <p>The DON was interviewed on 1/13/12 at</p>			
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	<p>2:30 p.m. The DON indicated she provided inservice training concerning C-diff to nursing and housekeeping staff. The DON indicated she did not address the cleansing of the surfaces including type of chemical to use and if chemical should be diluted. Through further interview of the DON on 1/17/12 at 3:05 p.m., the DON indicated she could not find any documentation in the information utilized to inservice the staff concerning C-diff, concerning the environment except for the area that indicated "...ensure consistent environment cleaning and disinfection; Hypochloride solutions may be required for cleaning if transmission continues."</p> <p>A facility policy titled "Clostridium Difficile," [no date] provided by the DON on 1/12/12 at 11:00 a.m., included, but was not limited to: "1. The facility has adopted Standard Precautions, and all residents' blood, body fluids, excretions, and secretions are considered potentially infectious. Residents with diarrhea associated with Clostridium difficile (i.e., residents who are colonized and symptomatic) will be placed on Contact Isolation Precautions. ...2. Residents considered at high risk of developing symptoms associated with Clostridium difficile include those with advancing age, ...and antibiotic or anti-neoplastic</p>						

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	<p>therapy. When residents with these risks have symptoms of diarrhea (i.e., three (3) loose stools in a twenty-four (24) period), a high degree of suspicion of Clostridium difficile should be demonstrated.</p> <p>Residents with previous infection who develop diarrhea should be evaluated as soon as practical. ...Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. 1. Disinfecting; and 2. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Infection Control Protocol and Safety 4. Wear appropriate personal protective equipment (e.g., gloves, gown, mask, eyewear, etc., as necessary) to prevent exposure to spills or splashes of blood or other potentially infectious materials. ..."</p> <p>"Guideline: 2. Transmission-Based Precautions (TBP): used when route of transmission is not completely interrupted using Standard Precautions alone, and the disease may have multiple routes of transmission. TBP are divided into three categories: a. Contact Precautions ...a. includes: wearing personal protective equipment (PPE) gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. ...3. Syndromic and empiric applications of</p>			
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	<p>Transmission-Based Precautions included: infections that warrant lab test results for diagnosis. a. Implement appropriate precautions per physician orders while test results are pending from laboratory. Precautions will continue if lab results are positive and remain in affect for the duration of the illness and while the resident remains infected. Discontinuing precautions will be determined based off of follow up lab results post antibiotic treatment ...4. Discontinuation of Transmission-Based Precautions: will be determined by the eradication of the pathogen along with negative laboratory results and per physician orders. a. C. Diff-two negative cultures at weekly intervals. The first sample must be obtained at least forty-eight hours post antibiotic treatment and must include both A and B toxins. ..."</p> <p>On 1/17/12 at 1:24 p.m. the DON was interviewed. The DON indicated she thought the staff were using red linen bags for residents with C-difficile. The DON also indicated the signs should have been placed alerting visitors to check with nursing staff prior to entering the residents' rooms.</p> <p>3.1-18(b)(2)</p>						