

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/18/2015
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NAME OF PROVIDER OR SUPPLIER  EASTGATE MANOR NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 14, 15, 16, 17, and 18, 2015</p> <p>Facility number: 000301 Provider number: 155341 AIM number: 100289090</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 4 Medicaid: 36 Other: 18 Total: 58</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on December 28, 2015.</p>	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	
F 0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			

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

TITLE

(X6) DATE

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

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SS=D Bldg. 00	<p><b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F 0225	<b>Resident#41 has voiced no further concerns and has</b>	01/15/2016			

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	<p>identify allegations of abuse, immediately report an allegation of abuse to the ISDH (Indiana State Department of Health), and thoroughly investigate allegations of abuse for 2 of 3 allegations reviewed. The facility also failed to notify a resident's family and physician of an allegation involving a resident for 1 of 3 allegations reviewed. (Resident #41, Resident #49, Resident #36)</p> <p>Findings include:</p> <p>1. During an interview on 12/14/15 at 2:46 P.M., Resident #41 indicated one evening while sitting in the dining room she had witnessed RN #15 pushing Resident #36 from the dining room in her merry walker (a mobility device). She indicated during the observation Resident #36 repeatedly put her feet down on the floor so the walker could not be moved and each time RN #15 would then jerk the walker backward roughly with Resident #36 sitting in it. She indicated at that time she had reported the incident to the facility but nothing had been done. The clinical record for Resident #41 was reviewed on 12/17/15 at 9:55 A.M., diagnoses included, but was not limited to, congestive heart failure, depression, peripheral vascular disease, and hypertension.</p> <p>A Quarterly Minimum Data Set</p>		<p><b>had no signs of negative psychosocial effect.</b></p> <p><b>Resident #36 has been monitored and has had no negative psychosocial effect. The resident's family and physician have been notified of the allegation.</b></p> <p><b>Resident #49 – A reportable event was made to ISDH about the missing items. The police were contacted and a report was made. The resident has not voiced any further concerns about missing items.</b></p> <p><b>Grievances/allegations will be reviewed by Executive Director to ensure investigation is complete and necessary concerns are reported to ISDH, family and physician.</b></p> <p>–□□□□□□□□ how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p><b>All residents have the</b></p>				

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	<p>assessment (MDS) dated 8/25/15, indicated Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15 indicated she was cognitively intact and had no behaviors.</p> <p>An Incident report dated 9/1/15 at 11:45 A.M., was provided by the facility on 12/14/15 at 3:00 P.M. The report included, but was not limited to, " ...Description added-9/1/2015 During internal QIS survey, [Resident #41] stated that she feels the nurse, [name of RN #15] was rough when pushing a resident's merry walker in the dining room on Sunday evening (8/30/2015) ...." The report lacked documentation of the Resident in the merry walker's name. The investigation was requested and reviewed. It contained 11 resident interviews. The investigation lacked a statement from Resident #41, RN #15 and any other staff of the facility. The clinical record for Resident #36 was reviewed on 12/17/15 at 2:00 P.M., the diagnoses included, but was not limited to, psychosis, anxiety, major depressive disorder, and dementia.</p> <p>A Quarterly MDS assessment dated 10/28/15 indicated Resident #36 had severely impaired cognition, inattention and disorganized thinking continuously</p>		<p><b>potential to beaffected.</b></p> <p><b>Allegations of abuse are thoroughlyinvestigated and reported in accordance with the state and facilitypolicies.</b></p> <p><b>The Executive Director, Director ofNursing Services and Social Service Director will be educated on the AbuseProhibition, Reporting and Investigation policy by the Regional Director ofOperations on or before 1/15/16.</b></p> <p><b>Staff will be educated on the AbuseProhibition, Reporting and Investigation Policy by the Executive Director on orbefore 1/15/16.</b></p> <p>-□□□□□□□□whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p><b>The Executive Director, Director of NursingServices and Social Service Director</b></p>	

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	<p>present.</p> <p>Resident #36's Nursing Notes were reviewed, the notes lacked any documentation the family and physician had been notified of the allegation. The notes also lacked documentation Resident #36 had been assessed following the allegation.</p> <p>The Social Service notes were reviewed, the notes lacked any documentation the family and physician had been notified of the allegation. The notes also lacked documentation Resident #36 had been assessed following the allegation.</p> <p>During an interview with the Administrator on 12/17/15 at 2:30 P.M., she indicated she became aware of the allegation on 9/1/15 during the company internal survey. She indicated Resident #41 had reported to a staff member that on the evening of 8/31/15 following supper RN #15 had been rough with Resident #36. She indicated following an investigation the allegation had been unsubstantiated. The Administrator indicated the Director of Nursing services (DNS) had completed the staff interviews and they would find documentation Resident #36's family and physician had been notified of the allegation.</p> <p>During an interview with the DNS on 12/17/15 at 3:00 P.M., she indicated no</p>		<p><b>will be educated on the Abuse Prohibition, Reporting and Investigation policy by the Regional Director of Operations on or before 1/15/16.</b></p> <p><b>Staff will be educated on the Abuse Prohibition, Reporting and Investigation Policy by the Executive Director on or before 1/15/16.</b></p> <p><b>Executive Director/designee will review each allegation of abuse to ensure the allegation is report and investigated per policy.</b></p> <p><b>Any noncompliance will be addressed with further education and/or disciplinary action as needed.</b></p> <p>-□□□□□□□ how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>-□□□□□□□ <b>To ensure</b></p>	

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	<p>further documentation could be provided for the allegation of abuse.</p> <p>The facility provided a list of all interviewable residents on 12/18/15 at 1:50 P.M. The list indicated there were 35 interviewable residents residing in the facility on 9/1/15 . At that time during an interview with the Administrator indicated only residents on the hall where RN #15 had worked were interviewed, she indicated RN #15 could have had contact with any and all residents in the facility. She indicated the investigation was not complete and thorough. She further indicated no documentation of notification of Resident #36's family and Physician could be provided.</p> <p>2. During an interview on 12/14/15 at 3:15 P.M., Resident #49 indicated he had multiple personal effects stolen while residing in the facility. He indicated a new camera, car keys, blankets and money, had all been stolen while he resided in the facility. He indicated he had reported all missing items to the facility and they would not assist him with locating the items.</p> <p>The clinical record for resident #49 was reviewed on 12/16/15 @10:14 a.m. the diagnoses included, but were not limited to, diabetes and post-traumatic stress disorder.</p>		<p><b>compliance, the Social Service Director/Designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</b></p>	

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	<p>An annual MDS assessment dated 9/7/15 indicated Resident #49 had a BIMS score of 13 indicating he was cognitively intact.</p> <p>The Social Service notes for Resident #49 were reviewed and included an untimed note dated 9/15/15 "Resident reported items stolen from room. [Name of Resident # 49] refuses to allow us to check his personal vehicle ... [Name of Resident #49] also refuses to file a police report..."</p> <p>The facility provided all reportable in the last 6 months on 12/14/15 at 3:00 P.M., no allegations of misappropriation reported by Resident #49 were provided. The administrator was notified of the allegation of misappropriation during an interview on 12/14/15 at 4:20 P.M., she indicated Resident #49 had frequently reported missing items, car keys, money, and camera. She indicated Resident #49 had a history of paranoia, and accusing staff of stealing from him. She indicated Resident #49 was care planned for these behaviors. She further indicated no investigation could be provided, and no police report had been filed.</p> <p>On 12/16/15 at 11:00 A.M., during an interview with Administrator, Resident #49 came to the office and reported a</p>			

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	<p>missing set of keys. He indicated at that time a locksmith had brought the keys to the facility and handed them to an unknown staff member and now they are missing.</p> <p>During an interview with the Administrator on 12/16/15 at 2:00 P.M., the Administrator indicated she had not reported the missing items as she felt it had been a behavior for Resident #49. Facility Reportable Incident #13 was provided by the administrator on 12/17/15 at 10:00 A.M. The report included, but was not limited to, "...12/16/15 at 3:01 P.M... [Name of Resident #41] reported missing items to the surveyor...Police report was made..."</p> <p>A policy titled "...ABUSE PROHIBITION, REPORTING, AND INVESTIGATION" dated July 2015, included, but was not limited to, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion and misappropriation of resident property and/or funds..." "...<u>Misappropriation of Resident Funds or Property</u> -the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without</p>			
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	<p>the resident's consent. Note: Residents' property includes all residents' possessions, regardless of their apparent value since it may hold intrinsic value to the resident ...If resident abuse is identified or suspected the following guidelines will be followed: 1. The resident (s) involved in the incident will be protected and/or removed from the situation immediately... Any individual who witnesses abuse or has the suspicion of, shall immediately notify the charge nurse of the unit, which the resident resides...Any staff member implicated in the alleged abuse will be removed from the facility at once...The Executive Director and/or Director of Nursing will be immediately notified of the report and the initiation of the investigation...The resident (s) involved in the incident will be assessed for injuries ...The physician will be notified and orders will be received for treatment ...The family of the resident (s) and/or responsible party will be notified ...Resident will be questioned (if alert and competent) about the nature of the incident and their statement will be put in writing ...An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...The investigation will</p>			

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F 0226 SS=D Bldg. 00	<p>include: Facts and observations by involved employees...witnessing employees...witnessing non-employees...others who might have pertinent information..." 3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure the facility abuse policy was implemented in regards to a complete and thorough investigation, reporting allegations to the State Department of Health and Resident family, and Physician for 2 of 3 allegations reviewed. (Resident #36, Resident #41, Resident #49) Findings include: 1. During an interview on 12/14/15 at 2:46 P.M., Resident #41 indicated one evening while sitting in the dining room she had witnessed RN #15 pushing Resident #36 from the dining room in her merry walker (a mobility device). She</p>	F 0226	<p>-□□□□□□□□whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice <b>Resident #41 has voiced no further concernsand has had no signs of negative psychosocial effect.</b> <b>Resident #36 has been monitored andhas had no negative psychosocial effect. The resident's family and physicianhave been notified of the allegation.</b> <b>Resident #49 – A reportable eventwas made to</b></p>	01/15/2016

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	<p>indicated during the observation Resident #36 repeatedly put her feet down on the floor so the walker could not be moved and each time RN #15 would then jerk the walker backward roughly with Resident #36 sitting in it. She indicated at that time she had reported the incident to the facility but nothing had been done. The clinical record for Resident #41 was reviewed on 12/17/15 at 9:55 A.M., diagnoses included, but was not limited to, congestive heart failure, depression, peripheral vascular disease, and hypertension.</p> <p>A Quarterly Minimum Data Set assessment (MDS) dated 8/25/15, indicated Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15 indicated she was cognitively intact and had no behaviors.</p> <p>An Incident report dated 9/1/15 at 11:45 A.M., was provided by the facility on 12/14/15 at 3:00 P.M. The report included, but was not limited to, " ...Description added-9/1/2015 During internal QIS survey, [Resident #41] stated that she feels the nurse, [name of RN #15] was rough when pushing a resident's merry walker in the dining room on Sunday evening (8/30/2015) ...." The report lacked documentation of the</p>		<p><b>ISDH about the missing items. The police were contacted and areport was made. The resident has not voiced any further concerns about missingitems.</b></p> <p><b>Grievances/allegationswill be reviewed by Executive Director to ensure investigation is complete andnecessary concerns are reported to ISDH, family and physician.</b></p> <p>-□□□□□□whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p><b>The Executive Director, Director of NursingServices and Social Service Director will be educated on the Abuse Prohibition,Reporting and Investigation policy by the Regional Director of Operations on orbefore 1/15/16.</b></p> <p><b>Staff will be educated on the AbuseProhibition, Reporting and Investigation</b></p>	
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	<p>Resident in the merry walker's name. The investigation was requested and reviewed. It contained 11 resident interviews. The investigation lacked a statement from Resident #41, RN #15 and any other staff of the facility.</p> <p>The clinical record for Resident #36 was reviewed on 12/17/15 at 2:00 P.M., the diagnoses included, but was not limited to, psychosis, anxiety, major depressive disorder, and dementia.</p> <p>A Quarterly MDS assessment dated 10/28/15 indicated Resident #36 had severely impaired cognition, inattention, and disorganized thinking continuously present.</p> <p>Resident #36's Nursing Notes were reviewed, the notes lacked any documentation the family and physician had been notified of the allegation. The notes also lacked documentation Resident #36 had been assessed following the allegation.</p> <p>The Social Service notes were reviewed, the notes lacked any documentation the family and physician had been notified of the allegation. The notes also lacked documentation Resident #36 had been assessed following the allegation.</p> <p>During an interview with the Administrator on 12/17/15 at 2:30 P.M., she indicated she was made aware of the</p>		<p><b>Policy by the Executive Director on orbefore 1/15/16.</b></p> <p><b>ExecutiveDirector/designee will review each allegation of abuse to ensure the allegationis reported and investigated per policy.</b></p> <p><b>Allreportables will be reviewed by the DNS Specialist to ensure the policy isfollowed and allegations are thoroughly investigated.</b></p> <p><b>Anynoncompliance will be addressed with further education and/or disciplinaryaction as needed.</b></p> <p>-□□□□□□□ howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;</p> <p>-□□□□□□□ <b>To ensure compliance, the Social Service Director/Designee isresponsible for the</b></p>				

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	<p>allegation on 9/1/15 during the company internal survey. She indicated the Resident #41 had reported to a staff member that on the evening of 8/31/15 following supper that RN #15 had been rough with Resident #36. She indicated following an investigation the allegation had been unsubstantiated. The Administrator indicated the Director of Nursing services (DNS) had completed the staff interviews and they would find documentation Resident #36's family and physician had been notified of the allegation.</p> <p>During an interview with the DNS on 12/17/15 at 3:00 P.M., she indicated no further documentation could be provided for the allegation of abuse.</p> <p>On 12/18/15 at 1:50 P.M., the facility provided a list of all alert and oriented residents in the facility on 9/1/15 it contained 35 residents. At that time during an interview with the Administrator indicated she indicated only residents on the hall RN #15 had worked were interviewed, she indicated RN #15 could have had contact with any and all residents in the facility. She indicated the investigation was not complete and thorough. She further indicated no documentation of notification of Resident #36's family and</p>		<p><b>completion of the Abuse Prohibition and Investigation CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</b></p> <p>-□□□□□□□□ by what date the systemic changes will be completed.</p> <p>-□□□□□□□□ <b>Jan. 15, 2016</b></p>		

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	<p>Physician could be provided.</p> <p>2. During an interview on 12/14/15 at 3:15 P.M., Resident #49 indicated he had multiple personal effects stolen while residing in the facility. He indicated a new camera, car keys, blankets and money, had all been stolen while he resided in the facility. He indicated he had reported all missing items to the facility and they would not assist him with locating the items.</p> <p>The clinical record for resident #49 was reviewed on 12/16/15 at 10:14 A.M. the diagnoses included, but were not limited to, diabetes and post-traumatic stress disorder.</p> <p>An annual MDS assessment dated 9/7/15 indicated Resident #49 had a BIMS score of 13 indicating he was cognitively intact.</p> <p>The Social Service notes for Resident #49 were reviewed and included an untimed note dated 9/15/15 "Resident reported items stolen from room. [Name of Resident #49] refuses to allow us to check his personal vehicle...[Name of Resident #49] also refuses to file a police report..."</p> <p>The facility provided all reportable in the last 6 months on 12/14/15 at 3:00 P.M., no allegations of misappropriation</p>			
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	<p>reported by Resident #49 were provided. The administrator was notified of the allegation of misappropriation during an interview on 12/14/15 at 4:20 P.M., she indicated Resident #49 had frequently reported missing items, car keys, money, and camera. She indicated Resident #49 had a history of paranoia, and accusing staff of stealing from him. She indicated Resident #49 had been care planned for these behaviors. She further indicated no investigation could be provided, and no police report had been filed.</p> <p>On 12/16/15 at 11:00 A.M., during an interview with Administrator, Resident #49 came to the office and reported a missing set of keys. He indicated at that time a locksmith had brought the keys to the facility and handed them to an unknown staff member and now they are missing.</p> <p>During an interview with the Administrator on 12/16/15 at 2:00 P.M., the Administrator indicated she had not reported the missing items as she felt it had been one of Resident #49's behaviors.</p> <p>Facility Reportable Incident #13 was provided by the administrator on 12/17/15 at 10:00 A.M. The report included, but was not limited to, "...12/16/15 at 3:01 P.M ... [Name of</p>			

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	<p>Resident #41] reported missing items to the surveyor...Police report was made ..." A policy titled "...ABUSE PROHIBITION, REPORTING, AND INVESTIGATION" dated July 2015, included, but was not limited to, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion and misappropriation of resident property and/or funds..." . "...<u>Misappropriation of Resident Funds or Property</u> -the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Note: Residents' property includes all residents' possessions, regardless of their apparent value since it may hold intrinsic value to the resident ...If resident abuse is identified or suspected the following guidelines will be followed: 1. The resident (s) involved in the incident will be protected and/or removed from the situation immediately ... Any individual who witnesses abuse or has the suspicion of, shall immediately notify the charge nurse of the unit, which the resident resides ...Any staff member implicated in the alleged abuse will be removed from</p>			

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F 0282 SS=D Bldg. 00	<p>the facility at once ...The Executive Director and/or Director of Nursing will be immediately notified of the report and the initiation of the investigation ...The resident (s) involved in the incident will be assessed for injuries ...The physician will be notified and orders will be received for treatment ...The family of the resident (s) and/or responsible party will be notified ...Resident will be questioned (if alert and competent) about the nature of the incident and their statement will be put in writing ...An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented.. The investigation will include: Facts and observations by involved employees...witnessing employees...witnessing non-employees...others who might have pertinent information ..."</p> <p>3.1-28(c)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and</p>	F 0282	- whatcorrective action(s) will be accomplished for those residents	01/15/2016

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	<p>record review, the facility failed to ensure a diuretic medication was clinically indicated or monitored for a resident who received diuretic medication for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #56)</p> <p>Findings include:</p> <p>Resident #56 was observed on 12/14/15 at 2:48 P.M., sitting in a wheelchair in the hallway in no apparent distress.</p> <p>The clinical record of Resident #56 was reviewed on 12/17/15 at 9:07 A.M. The record indicated the diagnoses of Resident #56 included, but were not limited to, congestive heart failure.</p> <p>The most recent Annual MDS [Minimum Data Set] assessment dated 1/27/15 indicated Resident #56 received diuretic medication daily.</p> <p>The most recent Quarterly MDS dated 9/15/15 indicated Resident #56 received diuretic medication daily.</p> <p>A Care Plan for Ineffective Tissue Perfusion dated 9/24/15 included, but was not limited to, interventions of, "...Administer meds [medications] as ordered..."</p>		<p>found to have been affected by the deficient practice; <b>Resident #56 received and is receiving medications as directed by the physician's order. There is documentation on the Medication Administration Record of medications received.</b> - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; <b>Residents who receive diuretic medications have been reviewed by DNS to ensure there is clinical indication for the medication and that appropriate monitoring has been documented. Licensed nursing staff will be educated by the DNS on the importance of administering and documenting medications as directed by the physicians' orders on or by 1/15/16. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nursing staff will be educated by the DNS on the importance of administering and documenting medications as directed by the physicians' orders on or by 1/15/16. The MAR's will be audited daily by the designated nurse manager to ensure there is appropriate documentation of medication received. Staff</b></p>	

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	<p>A Care Plan for Fluid Maintenance dated 9/24/15 included, but was not limited to interventions of, "...administer medications as ordered..."</p> <p>The December 2015 Physician's Order Recap included, but was limited to an order for, "Lasix [a diuretic medication] 40 mg [milligrams] ...give 1 tablet orally once a day for diuretic..."</p> <p>A Physician's Telephone Order dated 12/11/15 indicated a new order received for, "[arrow up] [increase] Lasix [a diuretic medication] 40 mg more a day X [times] 1 wk [week] then back to 40 mg a day"</p> <p>The December 2015 MAR [Medication Administration Record] indicated Resident #56 was to receive Lasix 40 mg at 8:00 A.M. and 1:00 P.M. from 12/12/15 through 12/19/15. The MAR lacked any documentation to indicate Resident #56 received the 1:00 P.M. dose of Lasix 40 mg on 12/14/15, 12/15/15, and 12/16/15.</p> <p>During an interview on 12/17/15 at 10:30 A.M., RN #7 indicated no documentation could be provided to indicate Resident #56 received Lasix as ordered on 12/14, 12/15, 12/16.</p>		<p><b>non-compliance with policy will be addressed with further education and/or disciplinary action as needed.</b> - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; - <b>The Refusal of Medications and Treatments CQI tool will be completed by the DNS/designee weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</b></p>	

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F 0314 SS=G Bldg. 00	<p>During an interview on 12/17/15 at 11:30 A.M. the DON [Director of Nursing] indicated no documentation could be provided to indicate the Lasix was administered on 12/14/15, 12/15/15, or 12/16/15 as ordered by the physician.</p> <p>During an interview on 12/17/15 at 2:00 P.M., the DON indicated no specific policy could be provided, but it was usual facility practice to administer medications as ordered by the physician.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 ensure proper care was provided to a resident admitted with pressure ulcers for 1 of 2 residents reviewed for pressure.</p>	F 0314	-□□□□□□□□whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;  <b>Resident #1 has</b>	01/15/2016

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	<p>(Resident #82)The facility also failed to ensure a dependent resident admitted without pressure ulcers was provided effective interventions to prevent the development of a stage 3 pressure ulcer on the right buttock, stage 3 pressure ulcer on the 5th toe right foot, and an unstageable pressure ulcer on the 4th toe right foot for 1 of 2 residents who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident #1 experiencing two stage 3 pressure ulcers and one unstageable pressure ulcer. (Resident #1, Resident #82)</p> <p>Findings include:</p> <p>1. During an observation on 12/15/15 at 10:46 A.M., Resident #1 was observed in bed, without socks, no blue foot protectors, and a blue round pad [foot elevator foam rings] wrapped around each ankle. At that time, Resident #1's toes on the right foot had no dressing in place and the contractured right foot was observed to be in contact with the mattress.</p> <p>The clinical record of Resident #1 was reviewed on 12/15/15 at 1:30 P.M. The clinical record indicated Resident #1 was admitted to the facility on 2/13/02 and diagnoses included, but were not limited</p>		<p><b>received wound treatments as directed by the physician. No new wounds have developed and the current wounds are almost healed.</b></p> <p><b>Resident #82 has received wound treatment as directed by the physician. The resident has not developed any new areas and the current wounds are improving.</b></p> <p>-□□□□□□□□ how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p><b>All residents with wounds were reviewed by DNS to ensure physician orders and care plans were followed.</b></p> <p><b>Nursing staff will be educated by the DNS/designee on positioning for pressure relief and wound prevention/management on or before 1/15/16.</b></p> <p>-□□□□□□□□ what measures will be put into place or what systemic changes will be made</p>	
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	<p>to, cerebral palsy, aphasia, epilepsy, severe intellectual disability, and contractures.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 9/30/15, indicated Resident #1 experienced severe cognitive impairment, was totally dependent for bed mobility, transfers, and was at risk for developing pressure ulcers.</p> <p>During an interview on 12/16/15 at 9:49 A.M., the Director of Nursing (DON) indicated all residents in the facility were considered at risk to develop pressure ulcers.</p> <p>The Care Plan for Resident #1 dated 10/5/15 was provided by the DON on 12/16/15 at 2:45 P.M., and it read as follows: "Resident has impaired skin integrity: shear on right little toe, and buttocks...scab R (right) 4th toe. 12/15/15...Approach Start Date: 10/5/15 Incontinent care as needed with peri wash and moisture barrier...Labs as ordered...Pressure reducing/redistribution mattress on bed...Supplements as ordered...float heels foam boots 11/18/10...Turn and reposition every 2 hours...Wound healing vitamins as ordered...Composure [pressure reducing mattress] 12/15/15..."</p>		<p>to ensure that the deficient practice does not recur;</p> <p><b>Nursing staff will be educated by the DNS/designee on positioning for pressure relief and wound prevention/management on or before 1/15/16.</b></p> <p><b>Weekly skin assessments will be completed by the licensed nursing staff and reviewed daily by the designated nurse manager for changes in skin integrity. The DNS/designee will assess any changes noted by the next day. The physician will be notified of any skin changes.</b></p> <p><b>Residents with pressure wounds will be observed by the DNS/designee daily on each shift to ensure the residents' care plans are being followed. Charge nurses will observe daily for proper positioning during their shift rounds to ensure the residents' care plans</b></p>	

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	<p>The Care Plan dated 10/5/15 was provided by the DON 12/16/15 at 2:45 P.M., read as follows: Category: Pressure Ulcer...Resident is at risk for skin breakdown related to immobility, contractures, inability to turn self, history of open areas...donuts under heels while in bed Heel protectors...house barrier - use as needed...Prop Legs up on pillows above waist while in bed...Staff must anticipate needs, Resident unable to communicate..."</p> <p>The Current Physician's Orders dated 12/1/15 through 12/31/15 indicated the following: "...BIL [bilateral] HEEL PROTECTORS ON AT ALL TIMES..." Dated 10/2/15. "...MAY USE HOUSE BARRIER CREAM EVERY SHIFT TO O/A (R) BUTTOCKS" Dated 11/13/15. "...PROP LEGS UP WITH PILLOWS WHEN IN BED ABOVE WAIST AS MUCH AS POSSIBLE..." Dated 11/18/15. "...FOAM RINGS TO (B) [bilateral] FEET TO ELEVATE OFF MATTRESS WHEN IN BED..." Dated 7/28/11. "...FORTIFIED FOOD TWICE A DAY..." Dated 7/30/15 "...TAB-A-VIT TABLET GIVE 1 TABLET ORALLY ONCE A DAY..." Dated 4/22/10. "...VITAMIN C 500 MG TABLET GIVE</p>		<p><b>arebeing followed.</b></p> <p><b>Noncompliance with proper positioning will be correctedimmediately for the resident. Further education regarding positioning forpressure relief will be provided to the responsible nursing staff. If needed,disciplinary action will occur for continued noncompliance.</b></p> <p>-□□□□□□□□howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;</p> <p>-□□□□□□□□The DNS/Designeeis responsible for the completion of the Wound/Skin CQI tool weekly times 4 weeks, monthly times 6and then quarterly to encompass all shifts until continued compliance ismaintained for 2 consecutive quarters. The results of these audits will bereviewed by the CQI committee overseen by the ED. If threshold of 95% is not</p>	

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	<p>1 TABLET ORALLY 2 TIMES A DAY FOR WOUND HEALING..." Dated 9/22/10.</p> <p>The laboratory Cumulative Report dated 10/14/15 indicated Resident #1's lab values (blood levels) were as follows: Total protein was low at 5.5 g/dl [grams per deciliter]. The normal range for protein is 6.4 - 8.2 g/dl. Albumin was low at 2.6 g/dl. The normal range for albumin is 3.0 - 4.8 g/dl.</p> <p>The laboratory Cumulative Report dated 11/11/15 indicated Resident #1's lab values (blood levels) were as follows: Total protein was low at 6.1 g/dl. The normal range for protein is 6.4 - 8.2 g/dl. Albumin was low at 2.8 g/dl. The normal range for albumin is 3.0 - 4.8 g/dl.</p> <p>The laboratory Cumulative Report dated 12/9/15, indicated Resident #1's lab values (blood levels) were as follows: Total protein was low at 5.5g/dl. The normal range for protein is 6.4 - 8.2 g/dl. Albumin was low at 2.9 g/dl. The normal range for albumin is 3.0 - 4.8 g/dl.</p> <p>The "ASC Nutrition Risk Assessment" form dated 12/8/15 indicated the</p>		<p><b>achieved an actionplan will be developed to ensure compliance.</b></p>		

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	<p>following for Resident #1 "...Ability to feed self...Total dependence...Skin conditions...shearing..." The assessment form lacked any documentation related to resident #1 had a low protein or that a supplement had been added.</p> <p>The "PHYSICIAN TELEPHONE ORDERS" dated 12/18/15 documented an order for: "...Beneprotein 1 scoop BID [two times a day] x times 30 days..."</p> <p>The "CNA ASSIGNMENT SHEET STATION 2" was provided by CNA #6 on 12/14/15 at 8:46 A.M., and it read as follows: "...bed next to wall, scoop, check and change q [every] 2 hours...use donuts to feet in bed...use draw sheet or lift pad to prevent shearing..." The CNA assignment sheet lacked documentation of the following interventions, bilateral heel protectors on at all times, prop legs up with pillows when in bed and above waist as much as possible.</p> <p>During an observation of a treatment on 12/15/15 at 3:01 P.M., RN #6 removed Resident #1's wet brief and cleaned the area on Resident #1's coccyx and buttocks with a peri wipe cloth. RN #6 indicated at that time she thought the area on Resident #1's right buttock was caused by shearing a couple of weeks ago. RN #6 indicated the DON was the wound</p>			

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	<p>care nurse and that the DON had measured all skin areas. The wound on the right buttock appeared as a full thickness tissue loss with a pink wound bed and a small amount of tan slough noted on the bed. A brown area was noted on right side of the wound. RN #6 further indicated Resident #1 had a history of pressure ulcers in the same locations. At that time, no socks or blue heel protectors were observed on the right foot or left foot. A blue padded circle [donut] was wrapped around each ankle. The 5th toe had no dressing in place. The wound appeared to be a 1 cm diameter full thickness tissue loss with pink/white/brown wound bed. The 4th toe on the right foot had an area 1/2 cm in diameter which was covered with a brown scab and no wound bed was visible. RN #6 indicated that even though the 4th toe was presently scabbed over, Resident #6 frequently rubbed the scab off by moving around in the bed. The 3rd toe had a small red area which was blanchable.</p> <p>During an observation of Resident #1's shower on 12/16/15 at 10:20 A.M., CNA #12 indicated she would finish washing Resident #1's peri area when she returned to the room and laid Resident #1 down on the bed. CNA #12 indicated she had washed Resident #1's barrier cream off</p>			

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	<p>with a soapy washcloth in the shower, but indicated there was still a little white left in the wound. CNA #12 said, "It's hard to get that off." After CNA #12 and CNA #10 used the Hoyer lift and placed Resident #1 on the bed, CNA #12 took a wet, soapy washcloth and vigorously washed the wound bed and the area around the wound removing some of the white and tan material that was on the wound bed. The wound bed was bright red with dots of blood noted on the red tissue. The right side of the wound had a small brown area. CNA #12 then took the INZO barrier cream with the 5% demethicone and zinc oxide and applied it liberally to Resident #1's open wound bed and buttocks. During an interview with CNA #12 at that time, CNA #12 indicated that CNA's applied the cream after they showered Resident #1 and whenever they changed Resident #1's depends.</p> <p>The 5th toe on the right foot was opened and slightly bleeding. It had slough and a brown area covering part of the wound.</p> <p>The 4th toe on the right foot had a brown 0.5 cm round wound.</p> <p>During an observation at 12/16/15 at 12:05 P.M., the DON opened Resident #1's brief and indicated she had not staged the area on Resident #1's buttock and right toes because they were the</p>			

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	<p>result of shearing. The DON was made aware of the small pinpoint spots of blood on Resident #1's brief where it had covered the wound on the right buttock. The DON took her gloved finger and removed the barrier cream covering the wound indicating the wound looked better. The wound appeared as a full thickness tissue loss. There was a small amount of tan slough which covered part of the wound bed. The right side of the wound had a small brown area. The right foot was observed to have a dressing, sock, blue heel protectors and the heel rested in the center of the blue round donut. The DON removed the sock and dressing from Resident #1's right foot and observed the wound indicating that the wound appeared "soupy because of the Bacitracin." During an interview the DON at that time, the DON indicated she had found the blue heel protectors in the closet and put them on Resident #1. The DON further indicated they had a difficult time keeping a dressing on Resident #1's toes because Resident #1 knocked them off. The DON indicated she would measure Resident #1's wounds on 2/17/15.</p> <p>Pressure ulcer right 5th toe:</p> <p>The "ASC New Skin Event" form dated 9/29/15 was provided by the DON on</p>			

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	<p>12/16/15 at 2:45 P.M., and it indicated that Resident #1 experienced shearing on the right 5th toe measuring 2 cm [centimeters] x1.7 cm x 0.1cm. The wound was described as "open bright red with small amount of blood." Treatment was Bacitracin and band aid twice a day and preventive measures were to place bilateral feet in blue donuts to keep feet off bed.</p> <p>The "ASC Non-Pressure Wound Skin Evaluation Report" dated 9/29/15 was provided by the DON on 12/16/15 at 2:45 P.M., and it indicated Resident #1 had developed an area of shearing to the right 5th toe measuring 2 cm x1.7 cm x 0.1 cm. The wound was described as pink and bleeding. The order was bacitracin and band aid twice a day.</p> <p>The Progress Note dated 9/29/15 at 11:00A.M., read as follows: "Noted area R [right] little toe open - looks to be a shearing from moving resident in bed..."</p> <p>The Progress Note dated 9/30/15 at 10:00A.M., read as follows: "IDT [Interdisciplinary Team] members present Reviewed area on toe...area on toe superficial and pink. Area looks sheared Blue donuts in place on bed to lift feet [arrow up] and prevent shearg [sic] when repositioning..."</p>			

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	<p>The Progress Note from the Nurse Practitioner dated 10/2/15 read as follows: "...Abrasion...right 5th toe, getting worse from moving around on the bed, currently bleeding...Float...heels to keep them from rubbing on the sheets...Heel boots are not in place today..."</p> <p>The Progress Note dated 10/17/15 at 2:10 P.M., read as follows: "...Tx [treatment] continues to toe. Rubs foot against bed et [and] bandage becomes dislodged..."</p> <p>The "ASC Non-Pressure Wound Skin Evaluation Report" dated 10/22/15 indicated the wound on Resident #1's right 5th toe measured 1.5 cm x 1.0 cm x 0.1 cm." The wound was described as pink and bleeds at times. The treatment was Betadine.</p> <p>The Progress Note dated 10/23/15 at 10:30 A.M., read as follows: "IDT member present. Area on toe healing. Tissue pink et granulation noted. Bil [bilateral] heel protectors on and floating feet to prevent further shearing in bed..."</p> <p>The Progress Note dated 10/26/15 untimed, read as follows: "...5th toe area dry and scabbed, heels floated while in bed..."</p>			

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	<p>The Progress Note dated 10/29/15 at 5:00 A.M., read as follows: "...Treatment to 5th toe cont [continues]...area remains open...lg [large] amt [amount] serous drng [drainage] noted..."</p> <p>The Progress Note dated 10/29/15 at 10:30 A.M., read as follows: "IDT member present. Area R [right] 5th toe remains open...Wears bil [bilateral] heel protectors and uses donuts to elevate feet to keep off of bed..."</p> <p>The Progress Note from the Nurse Practitioner dated 11/13/15, read as follows: "Problem #1 - Description...2 cm in diameter. Stage II. [two] Bleeding...Right Lower Extremity - fifth toe..."</p> <p>"Problem #2...Open area on...coccyx. Dime size, staff using house barrier cream currently..."</p> <p>"...Lower Extremity...No edema (Pedal pulse bilateral and equal. Skin temperature...Heel boots are not in place today..."</p> <p>The "ASC Non-Pressure Wound Skin Evaluation Report" dated 12/10/15, indicated the wound on Resident #1's right 5th toe was caused by shearing and measured .3 cm [centimeters] x .3 cm x 0.1 cm. The wound was described as</p>			

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	<p>scabbed. The treatment was Betadine.</p> <p>The "ASC Pressure Wound Skin Evaluation Report" dated 12/17/15, was provided by the DON on 12/18/15 at 10:16 A.M., and it read as follows: "R [right] 5th toe...existing area...Date area originally noted 9/29/15...Stage III [three]...Slough...sm [small] amt [amount] thin white... (Yellow or white tissue adhering to ulcer bed)...1.3 [cm] x 1.0 [cm] x 0.1 [cm]...Describe wound color...pink with white slough...Current treatment Bacitracin and cover..."</p> <p>Pressure ulcer to right buttock:</p> <p>The Progress Note dated 11/13/15 at 10:08 A.M., read as follows: "Shear noted on R [right] buttocks...N/O [new order] noted new tx [treatment] to R buttocks..."</p> <p>The "ASC New Skin Event" form dated 11/13/15 indicated Resident #1 experienced shear on the right buttock measuring 1.5 cm [centimeters] x .7 cm x 0.1 cm. The area was open and not draining. Preventative measures were to continue to turn and reposition every 2 hours and lift with a draw sheet or pad.</p> <p>The "ASC Non-Pressure Wound Skin Evaluation Report" dated 11/13/15,</p>			

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	<p>indicated Resident #1 had developed an open area to the right buttock measuring 1.5 cm x .8 cm x 0.1 cm. The wound was described as pink. The treatment order documented was for house cream every shift.</p> <p>The Progress note dated 11/23/15 at 3:00 A.M., read as follows: "...house barrier cream applied to buttocks. R [right] side area scabbed, L [left side remains reddened..."</p> <p>The "ASC Non-Pressure Wound Skin Evaluation Report" dated 12/10/15 indicated Resident #1 had an area of shearing on the right buttock measuring 0.6 cm x 0.4 cm x 0.1 cm. The wound was described as pink and healthy tissue. The treatment order documented was house barrier cream.</p> <p>The Progress Note dated 12/15/15 at 5:00 P.M., read as follows: "...Reported to DNS [Director of Nursing Services] from day nurse area R buttock has sml [small] amt [amount] scabbed area...Area on toe scab off with no drainage noted..."</p> <p>The "ASC Pressure Wound Skin Evaluation Report" dated 12/17/15 was provided by the DON on 12/18/15 at 10:16 A.M., and it read as follows: "R [right] buttock...existing area...Date area</p>			

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	<p>originally noted 11/13/15...Stage III [three]...Slough...sm [small] amt [amount] (Yellow or white tissue adhering to ulcer bed)...1.0 [cm] x 0.5 [cm] x 0.1 [cm]...Describe wound color...pink with sm. amt white slough...Current treatment house barrier - changed to Santyl and aquacell and cover..."</p> <p>Pressure ulcer to right 4th toe:</p> <p>The Progress Note dated 11/15/15 at 5:15 A.M., read as follows: "...Scabbed area on R [right] 4th toe noted...0.5 x 0.5 scabbed. will continue float heels. foam boots. to prevent [illegable] rubbing against bed."</p> <p>The "ASC Non-Pressure Wound Skin Evaluation Report" dated 12/15/15 indicated Resident #1 had a new area of scabbing on the right 4th toe measuring 0.5 cm x 0.5 cm." The wound was described as pink. The current treatment order documented was skin prep.</p> <p>The "ASC Pressure Wound Skin Evaluation Report" dated 12/17/15 was provided by the DON on 12/18/15 at 10:16 A.M., and it read as follows: "R [right] 4th toe...existing area...Date area originally noted 12/15/15. Unstageable ...Necrotic/eschar (Black, brown or tan</p>			

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	<p>tissue adheres to wound bed)...0.5 [cm] x 0.4 [cm]...not opened...dk [dark] brown/red intact...Current treatment skin prep..."</p> <p>During an interview on 12/17/15 at 10:00 A.M., CNA #6 indicated they placed Resident #1's feet on top of the donuts because Resident #1's toes touched the mattress whenever the donut was placed around the resident's ankles. CNA #6 further indicated that when she reported to work this morning she observed Resident #1's feet had fallen off the donuts and were on the mattress.</p> <p>During an observation on 12/17/15 at 11:35 A.M., the DON and the DNS Specialist completed the weekly measurement of Resident #1's wounds. At that time, the DNS Specialist indicated that if a stage 2 pressure ulcer had any slough on the wound bed it should be classified as a stage 3 pressure ulcer. The wound on Resident #1's right buttock and 5th toe right foot were determined to be Stage III [three] pressure ulcers and the 4th toe on the right foot was determined to be an unstageable pressure ulcer.</p> <p>At that time the DON was made aware there were observations of CNA's applying INZO barrier cream to the</p>			

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	<p>wound bed and that they were using soapy washcloths to wash the wound bed, after incontinence care, and during showering. The DON indicated at that time that only nursing staff should be performing treatments to pressure ulcers.</p> <p>During an interview with the DNS on 12/17/15 at 1:30 P.M., the DON indicated no manufacturer's information could be provided for the donut ring [foot elevator foam ring] or for the use of the INZO barrier cream as a treatment for open pressure wounds.</p> <p>A Policy and Procedure for "SKIN MANAGEMENT PROGRAM" was provided on 12/16/15 at 2:53 P.M. by the DON. The procedure read as follows: "1...The facility assigned wound care nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation event on the next business day..." The DON at that time indicated she used the "ASC Pressure Wound Skin Evaluation Report" to determine the stages of a pressure wound.</p> <p>2. On 12/15/15 at 8:05 A.M., Resident #82 was observed lying in bed with boots applied to the bilateral lower legs. The boots were observed to be improperly</p>			

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	<p>applied and the left heel was observed to not have complete pressure relief.</p> <p>During an interview on 12/15/15 at 10:33 A.M., RN #7 indicated Resident #82 was admitted to the facility on 12/4/15 with multiple pressure ulcers. RN #7 further indicated Resident #82 utilized special boots to provide pressure relief to the heels, and skin prep was applied to the heels for protection.</p> <p>During an interview on 12/15/15 at 11:42 A.M., RN #8 indicated Resident #82 was admitted to the facility with a Stage 4 pressure wound to the left trochanter and two deep tissue injuries.</p> <p>On 12/16/15 at 8:10 A.M., Resident #82 was observed lying in bed with boots applied to the bilateral lower legs. The boots were observed to be improperly applied and the left heel was observed to not have complete pressure relief.</p> <p>The clinical record of Resident #82 was reviewed on 12/16/15 at 9:00 A.M. The record indicated Resident #82 was admitted to the facility on 12/4/15 with diagnoses including, but not limited to, decubitus ulcers.</p> <p>The Admission Physician's Orders dated 12/4/15 included, but was not limited to,</p>			

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	<p>orders for, "...keep heels floated q [every] shift..."</p> <p>A Care Plan for Pressure Ulcer dated 12/4/15 included, but was not limited to interventions of, "...float heels-boots...turn and reposition every 2 hours..." The Plan lacked any documentation to indicate the assistance required for turning and repositioning.</p> <p>A Physician's Telephone Order dated 12/5/15 indicated a new order was received for, "...L [left] heel skin prep heel...Wear...boots and float heels while in bed..."</p> <p>The Admission MDS (Minimum Data Set) assessment dated 12/11/15 indicated Resident #82 experienced moderate cognitive impairment, required the extensive assistance of two staff for bed mobility, was at risk to develop pressure ulcers, was admitted with unhealed Stage 2, Stage 4, and 2 deep tissue injury pressure ulcers, received pressure ulcer care, and pressure reducing devices.</p> <p>During an interview on 12/16/15 at 9:49 A.M., the DON (Director of Nursing) indicated Resident #82 required the extensive assistance of 1 staff for slight adjustments in positioning while in bed and required the extensive assistance of</p>			

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	<p>two staff for complete adjustments in positioning while in bed.</p> <p>On 12/16/15 at 2:20 P.M., Resident #82 was observed lying in bed with boots applied to the bilateral lower legs. The boots were observed to be improperly applied and the left heel was observed to not have complete pressure relief.</p> <p>During an observation of care on 12/17/15 at 9:18 A.M., Resident #82 was observed lying in bed in a supine position. The DON (Director of Nursing) was observed to reposition Resident #82 to the right side by grasping a pad underneath and pulling the resident across the surface of the bed. The DON was then observed to expose the Left heel wound and rub the wound bed with a gloved finger and indicated the wound was closed. The DON was then observed to exit the room, return with a flashlight. During an interview, at that time, the DON indicated she was going to measure the left heel wound. The left heel wound bed was observed to be dark pink with a red, shiny center and measured 0.9 cm (centimeters) length X 2.0 cm width X 0.3 cm depth. The DON then indicated RN #7 would return to perform the treatment and the current treatment was to apply skin prep on the intact skin around the wound for protection. The</p>			

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	<p>DON was then observed to exit the room.</p> <p>On 12/17/15 at 9:30 A.M., RN #7 was observed to enter the room of Resident #82. During an interview, at that time, RN #7 indicated the current treatment for the left heel wound was to apply skin prep directly to the wound bed and was observed to touch the open wound bed with a bare finger to demonstrate. RN #7 then stated, "I am very into prevention." RN #7 then indicated she needed to get the skin prep and was observed to exit the room. RN #7 was then observed to re-enter the room of Resident #82, perform handwashing, and apply gloves. RN #7 was observed to apply skin prep directly to the open wound. Resident #82 was observed, at that time, to grimace.</p> <p>A Policy and Procedure for Wounds provided by the DON on 12/16/15 at 3:09 P.M. lacked any documentation related to dressing change techniques. During an interview, at that time, the DNS Specialist indicated no specific policies for positioning or proper wound care technique could be provided because it was common nursing knowledge and basic standards of practice.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			
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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a diuretic medication was clinically indicated or monitored for a resident who received diuretic medication for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #56)</p> <p>Findings include:</p>	F 0329	<p>-□□□□□□□□ what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p><b>Resident #56 has received medications as ordered by the physician. Resident #56 has been assessed by the physician to ensure</b></p>	01/15/2016

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	<p>Resident #56 was observed on 12/14/15 at 2:48 P.M., sitting in a wheelchair in the hallway in no apparent distress.</p> <p>The clinical record of Resident #56 was reviewed on 12/17/15 at 9:07 A.M. The record indicated the diagnoses of Resident #56 included, but were not limited to, congestive heart failure.</p> <p>The most recent Annual MDS (Minimum Data Set) assessment dated 1/27/15 indicated Resident #56 did not have a diagnosis of congestive heart failure, did experience shortness of breath or trouble breathing with exertion, and received diuretic medication daily.</p> <p>The most recent Quarterly MDS dated 9/15/15 indicated Resident #56 did not have a diagnosis of congestive heart failure, did experience shortness of breath or trouble breathing with exertion and lying flat, and received diuretic medication daily.</p> <p>A Care Plan for Ineffective Tissue Perfusion dated 9/24/15 included, but was not limited to, interventions of, "...observe for...any decreased urinary output...shortness of breath....abnormal lung sounds..." The plan lacked any intervention for monitoring of edema.</p>		<p><b>medications are clinically indicated. The care plan has been reviewed and updated with appropriate interventions related to edema. The MDS has been modified to reflect the diagnosis of congestive heart failure.</b></p> <p>-□□□□□□ how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p><b>Residents who receive diuretic medications have been reviewed by DNS to ensure there is clinical indication for the medication and that appropriate monitoring has been documented.</b></p> <p><b>Licensed nursing staff will be educated by the DNS on the importance of administering and documenting medications as directed by the physicians' orders on or by 1/15/16.</b></p> <p><b>Licensed nursing staff will be educated on the importance of clinical</b></p>				

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	<p>The December 2015 Physician's Order Recap included, but was limited to an order for, "Lasix [a diuretic medication] 40 mg [milligrams] ...give 1 tablet orally once a day for diuretic..."</p> <p>A Physician's Telephone Order dated 12/11/15 indicated a new order received for, "[arrow up] [increase] Lasix [a diuretic medication] 40 mg more a day X [times] 1 wk [week] then back to 40 mg a day"</p> <p>The December 2015 MAR [Medication Administration Record indicated Resident #56 was to receive Lasix 40 mg at 8:00 A.M. and 1:00 P.M. from 12/12/15 through 12/19/15. The MAR lacked any documentation to indicate Resident #56 received the 1:00 P.M. dose of Lasix 40 mg on 12/14/15, 12/15/15, and 12/16/15.</p> <p>The Nursing notes from 12/8/15 at 10:45 P.M. through 12/11/16 at 6:45 P.M. were reviewed and lacked any documentation to indicate Resident #56 experienced any signs of fluid overload.</p> <p>A Physician's Nursing Home Note dated 12/9/15 indicated, "...has chronic systolic heart failure....does not have any signs of fluid overload..."</p>		<p><b>indications for administering medications and documenting assessments related to medication changes by the DNS/designee on or before 1/15/16. The licensed nursing staff will also be educated on the importance of documenting on-going assessments for residents with recent changes in medication.</b></p> <p><b>Physician orders for medication changes will be reviewed daily by the nurse manager to ensure there is documentation related to the reason for the medication change.</b></p> <p><b>The physician will be contacted for further clarification if unable to determine the clinical indication for a medication</b></p> <p><b>Noncompliance with documentation will be addressed with the responsible staff with further education and/or disciplinary action.</b></p>	

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	<p>A Nursing note dated 12/11/15 at 7:00 P.M., indicated the Lasix dosage had been increased and lacked any documentation related to a clinical indication for the increase.</p> <p>A Dietary Progress note dated 12/15/15 indicated the Lasix had been increased and lacked any documentation related to a clinical indication for the increase or monitoring of the effects of diuretic therapy.</p> <p>During an interview on 12/17/15 at 10:30 A.M., RN #7 indicated no documentation could be provided to indicate Resident #56 received Lasix as ordered on 12/14/15, 12/15/15, 12/16/15. RN #7 further indicated no documentation could be provided to indicate a clinical indication for the increase of Lasix, or to indicate Resident #56 was monitored for the effects of diuretic therapy.</p> <p>During an interview on 12/17/15 at 11:30 A.M., the DON [Director of Nursing] indicated no documentation could be provided to indicate the Lasix was administered on 12/14/15, 12/15/15, or 12/16/15 as ordered by the physician.</p> <p>During an interview on 12/17/15 at 2:00 P.M., the DON indicated no specific</p>		<p>what measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur;</p> <p><b>Licensed nursing staff will beeducated by the DNS on the importance of administering and documentingmedications as directed by the physicians' orders on or by 1/15/16.</b></p> <p><b>Licensed nursing staff will be educated bythe DNS/designee on the importance of clinical indications for administeringmedications and documenting assessments related to medication changes on orbefore 1/15/16. The licensed nursing staff will also be educated on theimportance of documenting on-going assessments for residents with recentchanges in medication.</b></p> <p><b>Physician orders for</b></p>	

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	<p>policy could be provided related to clinical indications for medications or monitoring for the effect of medication use, but it was usual facility practice to have a clinical indication for every medication and to monitor the effects of medication. The DON further indicated no documentation could be provided to indicate a clinical indication for diuretic increase or the effects of the diuretic therapy were monitored.</p> <p>The Physician's Desk Reference 2015 Edition Nurse's Drug Handbook pages 439-440 indicated, "... Indications: Treatment of edema associated with congestive heart failure...Warnings/Precautions: May lead to profound diuresis with water and electrolyte depletion...careful medical supervision required..."</p> <p>3.1-48(a)(3)</p>		<p><b>medication changes will be reviewed daily by the nurse manager to ensure there is documentation related to the reason for the medication change.</b></p> <p><b>Noncompliance with documentation will be addressed with the responsible staff with further education and/or disciplinary action. The physician will be contacted for further clarification if unable to determine the clinical indication for a medication.</b></p> <p>-□□□□□□□□ how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>-□□□□□□□□ <b>To ensure compliance, the DNS/Designee is responsible for the completion of the Unnecessary Medication CQI tool weekly times 4 weeks, monthly times 6 and then</b></p>		

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F 0353 SS=E Bldg. 00	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was available to ensure call lights were answered in a</p>	F 0353	<p><b>quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The results of these audits will be reviewed by the CQI committeeoverseen by the ED. If threshold of 95%is not achieved an action plan will be developed to ensure compliance.</b></p> <p>-□□□□□□□□whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the</p>	01/15/2016

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	<p>timely manner and beds were made according to policy for 5 of 8 resident council minutes reviewed, 5 of 16 stage 1 resident interviews completed and 1 of 3 stage 1 family interviews completed. (Resident #11, Resident #53, Resident #33, Resident #39, Resident #76, Resident #200)</p> <p>1. During an interview on 12/14/15 at 2:32 P.M. Resident #11 indicated she often had to wait for 30 min prior for her call light to be answered when she needed to get up or lay down.</p> <p>2. During an interview on 12/14/15 at 2:41 P.M., Resident #53 indicated he had waited long periods of time before receiving CNA assistance. He further indicated he had told the facility they need more help. Resident #53 said, "I have timed it. I have a clock right in front of me and lots of times it has taken 45 minutes or longer."</p> <p>3. During an interview on 12/14/15 at 2:55 P.M., Resident #33 indicated that sometimes 30 minutes passed before receiving assistance and that the facility needed more CNA's. Resident #33 said, "I'm waiting right now. I already rang them and they said they will be back and I'm waiting right now to go to the bathroom and back to bed."</p>		<p>deficient practice; <b>Residents #11, 53, 33, 39 and 76 indicate they have been receiving the assistance they request in a more timely manner. Unable to identify resident #200. Other residents were interviewed for potential concerns about staffing or making of beds.</b> <b>Residents' beds are being changed and made per the facility policy</b></p> <p>- how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p><b>Residents have been interviewed for potential concerns about staffing or making of beds.</b></p> <p><b>Staff will be inserviced by the Executive Director on the importance of responding timely to call lights on or before 1/15/16.</b></p> <p><b>The DNS will inservice the nursing staff on the importance of changing bed linens per policy on or before 1/15/16.</b></p>				

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	<p>4. During an interview on 12/15/15 at 2:44 P.M., Resident #39 indicated that sometimes she had to wait a long time to go to the bathroom because they didn't have enough staff. Resident #39 said, "I think I'm not going to make it to the bathroom in time. They make it in here just in the nick of time."</p> <p>5. During an interview on 12/15/15 at 3:15 P.M., Resident #76 indicated that just last week one hour passed before assistance arrived whenever Resident #76 wanted to go to bed after using the call light. Resident #76 said, "I pushed the button. They came and said we will be back and it was an hour before they came back."</p> <p>6. During a confidential family interview on 12/15/15 at 3:20 P.M. A family member of Resident #200 indicated they often had to wait in excess of 30 minutes for the call light to be answered and Resident #200 experienced incontinence while waiting.</p> <p>7. The resident council minutes were reviewed and included, but were not limited to: April 20, 2015 "Call lights are not being answered in a timely manner." May 2015, "Call lights not being</p>		<p>-□□□□□□□ whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p><b>Staff will be inserviced by the ExecutiveDirector on the importance of responding timely to call lights on or before 1/15/16.</b></p> <p><b>The DNS/designee will inservicenursing staff on the importance of changing bed linens per policy on or before1/15/16.</b></p> <p><b>The ED/designee will complete anaudit weekly of call light response staggering the times to encompass allshifts</b></p> <p><b>Charge nurses will review showersheets for bed linen changes daily. Nurse manager will review weekly.</b></p> <p><b>Residents will be interviewed by thecustomer care representative daily regarding staff response to carerequests/call light and changing of bed linens</b></p>	

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	<p>answered or a CNA goes in and turns it off and doesn't come back...Beds do not get changed when showers done"</p> <p>June 15, 2015 "Bedding still not getting changed as often as it should"</p> <p>July 20,2015 "Beds not getting changed...Callights not being answered"</p> <p>October 19, 2015 "Call lights not being answered timely"</p> <p>8. The CNA assignment sheets provided by the DNS on 12/14/2015 at 2:00 P.M., indicated the following:</p> <p>Station 1-(Total 23 residents) with 2 CNA:</p> <p>13 residents at risk for falls</p> <p>18 residents needing assistance with ADL's (activities of daily living)</p> <p>7 residents requiring assistance with turning and repositioning</p> <p>4 residents needing heels floated</p> <p>9 residents requiring assistance with toileting</p> <p>7 residents requiring 2 assistance</p> <p>3 residents requiring mechanical lift for transfers</p> <p>Skilled Nursing Station-(Total 17 residents) with 1 CNA:</p> <p>17 residents at risk for falls</p> <p>10 residents requiring assistance with ADL's</p> <p>9 residents requiring assistance with</p>		<p><b>Any concerns voiced will be addressed immediately, grievance completed, corrective action implemented and follow up with the resident</b></p> <p><b>Noncompliance will be addressed with further education and/or disciplinary action as needed.</b></p> <p>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>- To ensure compliance, the DNS/Designee is responsible for the completion of the Accommodation of Needs CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the</p>	

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	<p>turning and repositioning 7 residents requiring heels floated 7 residents requiring assistance with toileting 10 residents requiring 2 assist for transfers 2 resident requiring a mechanical lift</p> <p>Station 2-(Total 24 residents) with 2 CNA's: 9 at risk for falls 23 residents requiring assistance with ADL's 10 residents requiring assistance with turning and repositioning 6 residents requiring heels floated 14 residents requiring assistance with toileting 8 resident requiring 2 assist for transfers 2 resident requiring a mechanical lift</p> <p>During an interview on 12/18/15 at 1:15 P.M., with the Staffing Coordinator #3 she indicated she used the provided budget to allot hours for the nursing staff. She indicated currently the nurses worked 12 hour shifts and they staffed 3 nurses on day shift, and 2 nurses on nights. She further indicated they staffed 5 CNA's for days and evening shift and 3 on nights to care for residents.</p>		<b>ED. If threshold of 95% is not achieved an actionplan will be developed to ensure compliance.</b>	

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F 0441 SS=D Bldg. 00	<p>9. During an interview with the DNS on 12/18/15 at 1:10 P.M., she indicated the facility did not have a specific policy related to staffing or call lights. She further indicated it was the policy of the facility to provide enough staff to ensure the needs of all residents were met.</p> <p>3.1-17(a) 3.1-17(b)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155341	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/18/2015
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NAME OF PROVIDER OR SUPPLIER  EASTGATE MANOR NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
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	<p>must isolate the resident.</p> <p>(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.</p> <p>(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 ensure clean technique was followed during a wound treatment and proper handwashing was performed for 1 of 4 residents who met the criteria for dressing changes. (Resident #82)</p> <p>Findings include:</p> <p>During an observation of care for Resident #82 on 12/17/15 at 9:18 A.M., the DON (Director of Nursing) picked up a black, plastic object from the floor with an ungloved right hand and place on the bedside table. The DON was then observed to not perform handwashing or hand hygiene and apply gloves. The DON was then observed to expose the left heel wound and rub the wound bed with a gloved finger.</p>	F 0441	<p>-□□□□□□□□whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Resident #82 has received wound care and dressing changes followingproper infection control practices, including appropriate hand hygiene</b></p> <p>-□□□□□□□□howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Residents who require a wound dressingchange have the potential to be affected.</b></p>	01/15/2016

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	<p>During an observation on 12/17/15 at 9:30 A.M., RN #7 demonstrated how to apply skin prep, touched the left heel wound of Resident #82 with a bare finger, and stated, "I am very into prevention." RN #7 then indicated she needed to get the skin prep and was observed to exit the room. RN #7 was then observed to re-enter the room of Resident #82, perform handwashing for less than 10 seconds and apply gloves. RN #7 was observed to open a package of skin prep, grasp the inner surface of a trash can with a gloved right hand and pull the trash can towards her, drop the packaging into the can, and apply skin prep directly to the open wound.</p> <p>During an interview on 12/17/15 at 2:17 P.M., the DON indicated handwashing should have been performed after touching the black plastic object on the floor and RN #7 should have performed handwashing for more than 10 seconds and should have performed handwashing after touching the inner surface of the trashcan with gloved hands.</p> <p>A Nursing Staff Infection Control policy provided by the HFA (Health Facilities Administrator) on 12/15/15 at 8:54 A.M. indicated, "...General Resident Care: Administer treatments as ordered according to professional standards..."</p>		<p><b>Nursing staff will be educated by the Clinical Education Coordinator on infection control practices related to wound care, dressing changes and hand washing on or before (date). Licensed nursing staff were observed for wound dressing skill validation.</b></p> <p>-□□□□□□□ what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p><b>Nursing staff will be educated by the Clinical Education Coordinator on infection control practices related to wound care, dressing changes and hand washing on or before (date)</b></p> <p><b>The CEC/designee will observe at least one dressing change weekly on each shift to ensure compliance with proper procedure.</b></p>	

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	<p>An Infection Control policy provided by the HFA on 12/14/15 at 10:00 A.M. indicated, "...goals of ...program...decrease the risk of infection...implementation of acceptable standards of practice ..."</p> <p>A Policy for Hand Hygiene provided by the DON on 12/17/15 at 2:00 P.M., indicated, "...moments for Hand Hygiene...before touching a patient, before clean...procedure, after body fluid exposure risk, after touching a patient, after touching patient surroundings..."</p> <p>The policy lacked any documentation to indicate the acceptable timeframe for performing handwashing.</p> <p>3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(1)</p>		<p>-□□□□□□□□ howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;</p> <p>-□□□□□□□□ <b>To ensure compliance, the CEC /Designee is responsible for the completion of the DressingChange skills validation check 3 times weekly for 1 weekly, twice weekly for 1 week, weekly times 2 weeks, and monthly for six months. Results of the skillsvalidation will be reviewed by the CQI committee overseen by the ED. If 95%compliance is not achieved an action plan will be developed to ensurecompliance.</b></p>	