

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
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NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F000000	<p>This visit was for the Investigation of Complaint IN00129915.</p> <p>Complaint: IN00129915 - Substantiated. Federal/State deficiencies related to the allegations are cited at F222, F312, F314, F315, F425 and F441.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: June 26 & 27, 2013</p> <p>Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 64 Total: 64</p> <p>Census Payor Type: Medicare: 7 Medicaid: 44 Other: 13 Total: 64</p> <p>Sample: 7</p>	F000000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.	

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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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on July 1, 2013.</p>				

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure personal privacy, in that when a resident received incontinent care, the nursing staff failed to provide personal privacy to a dependent resident for 1 of 3 cognitively impaired residents in a sample of 7. (Resident "E").</p>	F000164	<p>1. CNA's #8 and 9 received an employee coaching plan and education related to resident rights for personal privacy during care. Resident F is cognitively impaired and was unable to recall event2. Any cognitively impaired resident has a potential to be affected. Personal care observations were completed by</p>	07/27/2013

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	<p>Findings include:</p> <p>Observation on 06-26-13 at 11:35 a.m., Resident "E" was observed seated in a wheelchair and transported to the North Dining Room with the assistance of a CNA (Certified Nurses Aide). The resident remained seated at the table throughout the lunch period, and remained seated in the wheelchair until approximately 1:45 p.m., when the resident was ambulated to a recliner. When interviewed if the resident had previously been toileted, CNA #8 indicated "no." With the assistance of a therapy staff member and CNA #8, the resident was ambulated to her room.</p> <p>During this observation, Resident "F", the resident's roommate was seated in her wheelchair, adjacent to the end of the resident's bed. The CNA and therapist assisted the resident to bed, and the therapist pulled the privacy curtain, between the two beds. As the therapist exited the resident room, she closed the door.</p> <p>CNA #8 exited the resident room, returned to the resident's room with CNA #9. CNA #8 indicated she "needed help" with taking care of the</p>		<p>a nurse unit manager on all residents identified as cognitively impaired,(utilizing their last BIM's score) to ensure privacy was provided during personal care. Any failure to provide personal privacy during care was reported to the DON for investigation.3.An inservice was held on 7/15/13 & 7/22/13 for all nursing staff on resident rights to privacy during personal care. Visual reminders were placed in resident personal care areas to increase awareness and will remain in place for 3 months. 10% of residents identified as cognitively impaired (by their last BIM's score) will have personal care observations completed by a nurse unit manager or designee weekly, to ensure privacy during personal care. Any failure to provide personal privacy during care will be reported to ther DON for investigation. 4. Social Service Director or designee will complete Dignity & Privacy reviews, utilizing the Dignity & Privacy performance improvement tool, on three residents weekly x 4 weeks, then monthly x 3 months then quarterly. The results of the personal care observaations, the Dignity & Privacy performance tool and any investigations will be submitted and discusst at the QAPI meeting.ADON responsible for training, DON, Social Service Director to monitor and report to QAPI5. Date of Completion: 07/27/13</p>				

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	<p>resident. The two CNA's removed the resident's slacks and incontinent brief, by moving the resident from side to side. The resident was incontinent of bowel and bladder.</p> <p>The CNA's completed the care needs of Resident "E," including performing incontinent care, while Resident "F" remained at the edge of the privacy curtain, but in full view of watching the CNA's provide care to Resident "E."</p> <p>3.1-3(p)(4)</p>				

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F000222 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on record review and interview the facility failed to ensure cognitively impaired residents were not subjected to chemical restraints, in that when the facility had residents who had physician orders for "as needed" controlled pain medication, and had a cognitive impairment, the facility failed to ensure narcotic analgesic medications were not used for the purpose of chemical restraint or staff convenience for 2 of 2 residents reviewed for controlled pain medications in a sample of 7. This deficient practice had the potential to effect all cognitively impaired residents. (Residents "A" and "G").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-26-13 at 11:00 a.m. Diagnoses included but were not limited to dementia with behaviors, lack of coordination, congestive heart failure, altered mental status, and atrial fibrillation. These diagnoses remained current at the time of the</p>	F000222	<p>1. The MAR and conrolled Substance Records for residents A&G were reviewed on 6/27/13 for indications that prn narcotic anlgesics were being given as a chemical restraint or for staff convenience. As a result of this review, Licensed Nurse #14 was suspended pending investigation. During the interview njurse #14 admitted to giving prn narcotic analgesics to residents A&G for purposes other than to treat the medical systpton as was ordered by the physician. Nurse #14 was terminated upon completion of the investigation. on 6/24/13.2. Any cognitively impaired resident with an order for controlled substances could have the potential to be affected. The June 2013 MAR and Controlled Substance Records for all cognitively impaired residents receiving prn narcotic analgesics were reviewd by the pharmacist on 7/10/13 and 7/11/13 for indications they were being given as a chemical restraint or for staff convenience. There was no indications any nurse had used controlled substances improperly, except Nurse#14.3.The MAR and Contolled Substance Records for</p>	07/27/2013	

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	<p>record review.</p> <p>Review of the current Physician rewrite for the month of June 2013, indicated the resident had physician orders, originally dated 03-04-13 for Tramadol (an opoid analgesic controlled substance medication) 50 mg (milligrams) by mouth two times a day as needed for pain. This re-write also indicated the resident had Tylenol (an analgesic) 650 mg by mouth every four hours as needed for pain.</p> <p>The resident's MDS (Minimum Data Set) assessment, dated 05-30-13 indicated the resident received pain medication and staff assessment was needed to address the resident's vocal complaints or facial expressions of pain.</p> <p>The current plan of care, originally dated, 09-13-12 indicated "subject - pain interventions." An approach to this "subject" included Tramadol 50 mg by mouth BID (two times a day) PRN (as needed) for pain."</p> <p>A Quarterly Data Collection Tool, dated 05-29-13 indicated when the nurse asked the resident to "rate" his pain, the nurse documented the resident "just looked at writer non</p>		<p>all cognitively impaired residents on prn narcotic analgesics will be reviewed weekly the by the unit managers for indications that they were being given as a chemical restraint or for staff conviences and any indicators will be reported to the DON for investigation. An inservice was completed for licensed nurses and QMA's on 7/15/13 on maintaining a chemical restraint free environment.4. The pharmacist is to conduct a monthly audit of the MAR and Controlled Substance Records for the previous month on allo cognitively imparied resident receiving prn narcotic analgesics for any indication of them being used as a chemical restraint or for staff convenience. Any indications will be reported to the DON for investigaiton. The results of the pharmacgist audit and any investigations will be discussed at the montly QAPI meetingUnit Managers and pharmacists responsible, DON to monitor and report to QAPI.5. Date of Completion: 07/27/13</p>		

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	<p>sensical 'I love you.'" Current pain treatment: Tramadol PRN. This Pain assessment checklist of non-verbal indicated - scale B, was a handwritten notation "No s/sx [signs or symptoms]."</p> <p>The resident "Controlled Substances Record" was reviewed. During this review Licensed Nurse #14 dispensed the medication Tramadol to the resident on the following dates and times:</p> <p>April 19 at 4:00 p.m., April 22 at 4:00 p.m., April 23 at 4:00 p.m., April 25 at 4:00 p.m., April 26 at 4:00 p.m., April 27 at 4:00 p.m., and April 28 at 4:00 p.m.</p> <p>May 10 at 6:00 p.m., May 11 at 6:00 p.m., May 12 at 6:00 p.m., May 20 at 7:00 p.m., May 21 at 7:00 p.m., May 22 at 7:00 p.m., May 23 at 6:00 p.m., May 24 at 7:00 p.m., May 25 at 7:00 p.m., and May 26 at 7:00 p.m.</p> <p>Review of the Medication Record for May 2013 notes for the "reason" the medication given to the resident by Licensed Nurse #14 indicated "c/o [complaints of] generalized pain - no relief with repositioning - helpful [time indicated]." This notation was repeated for each entry. However the</p>						

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	<p>"notation" section lacked documentation the medication was dispensed on May 12 or May 26, 2013.</p> <p>June 3 at 7:00 p.m., June 4 at 8:00 p.m., June 5 at 8:00 p.m., June 6 at 8:00 p.m., June 7 at 9:00 p.m., June 8 at 9:00 p.m., June 9 at 9:00 p.m., and June 15 at 9:00 p.m.</p> <p>Review of the Medication Record for June 2013 notes for the "reason" the medication was given by Licensed Nurse #14 to the resident indicated, "c/o general pain - no relief with repositioning - helpful at [time indicated]." However further review of this record indicated the medication was also dispensed on June 9, 15, and 16, 2013 without documentation of the "reason" the medication was given to the resident, and the dosage given on June 16th, according to the Controlled Substances Record, was not recorded.</p> <p>2. The record for Resident ""G" was reviewed on 06-27-13 at 12:00 p.m.</p> <p>Diagnoses included, but were not limited to, dementia with behaviors, hypertension, anxiety, cardiomyopathy and vascular dementia. These diagnoses</p>						

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	<p>remained current at the time of the record review.</p> <p>The current Physician Re-write for June 2013, indicated the resident had physician orders, dated 05-14-13 for Norco (a narcotic analgesic) 5/325 mg three times a day as needed for pain. This re-write also indicated the resident had Tylenol (an analgesic) 650 mg by mouth three times a day for pain.</p> <p>The resident's MDS, dated 05-30-13 indicated the resident had orders for PRN pain medication and that pain was present but (resident) unable to answer.</p> <p>Review of the resident's current plan of care, originally dated 01-11-12 indicated "Has c/o pain all over for years." An approach to this "subject" indicated the resident had a current physician order for the narcotic analgesic.</p> <p>A Quarterly Data Collection Tool, dated 05-14-13 indicated the nurse was unable to rate the resident's pain, "couldn't respond to pain question, just looked at writer and asked 'Do you know who I am.' Current pain treatment: Norco PRN." This Pain assessment checklist of non-verbal</p>			

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	<p>indicated - scale B, was a handwritten notation "No s/sx [signs or symptoms] Hospice, vascular dementia."</p> <p>A review of the "Controlled Substances Record," indicated Licensed Nurse #14 dispensed the medication Norco to the resident on the following dates and times:</p> <p>May 20 at 6 p.m., May 21 at 6 p.m., May 22 at 6 p.m., May 23 at 6 p.m., May 24 at 6 p.m., May 25 at 6 p.m., and May 26 at 6 p.m.</p> <p>The reverse side of the Administration Record indicated Licensed Nurse #14 "reason" the resident required the medication was "generalized pain - no relief with repositioning - helpful at (time indicated)."</p> <p>June 3 at 6 p.m., June 4 at 6 p.m., June 5 at 6 p.m., June 6 at 6 p.m., June 7 at 8 p.m., June 8 at 8 p.m., June 9 at 8 p.m., June 15 at 8 p.m., June 18 at 8 p.m., June 19 at 8 p.m., June 20 at 8 p.m., June 21 at 8 p.m., June 22 at 8 p.m., and June 23 at 20:00.</p> <p>The reverse side of the administration record for June 2013 also indicated for each entry "reason" Licensed Nurse #14 gave the resident the</p>						

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	<p>medication was "generalized pain - no relief with repositioning - helpful at (time indicated)."</p> <p>In addition the record lacked documentation of the June 9th dose, and lacked documentation for the "reason" for the June 16th dose.</p> <p>Review of the facility policy on 06-27-13 at 12:50 p.m., titled "Pain Assessment," and dated 01-04-12 indicated the following:</p> <p>"Policy - Residents will be assessed for pain upon admission, readmission, quarterly, annually, upon significant change, when a resident experiences a new onset of pain or experiencing uncontrolled pain...</p> <p>Procedure - A weekly review of pain will be completed on the Weekly Progress Notes. A Pain Flow Record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they have pain...</p> <p>Record the following: 1. Date and time, 2 Site and location, 3. Type of pain, 4. Intensity, 5. Precipitating/aggravating, 6. Interventions - non-med</p>			

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	<p>[medication]/medication, 7. Intensity of pain after intervention, 8. Side effects, and 9. Initials...."</p> <p>During an Interview on 06-27-13 at 1:20 p.m., the Assistant Director of Nurses indicated, there were no pain flow sheets or progress notes for Resident's "A" and "G".</p> <p>During the Exit conference on 06-27-13 at 3:00 p.m., the Administrator indicated it was the responsibility of the Pharmacy Tech. (technician) to recognize and monitor the controlled drugs.</p> <p>This Federal tag relates to Complaint IN00129915.</p> <p>3.1-3(w)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review, observation and interview, the facility failed to ensure timely incontinent care, in that when residents were dependent upon staff for incontinent care the nursing staff failed to assist the residents in timely toileting needs for 2 of 3 dependent residents reviewed in a sample of 7. (Residents "A", and "E").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-26-13 at 11:00 a.m.</p> <p>Diagnoses included, but were not limited to, dementia with behaviors, lack of coordination, congestive heart failure, altered mental status, and atrial fibrillation. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS (Minimum Data Set) assessment, dated 05-30-13 indicated the resident was occasionally incontinent of bowel</p>	F000312	<p>1. Resident A and E were provided incontinence care at the time of request by surveyor. CNA#8 and #12 received an employee coaching plan and education related to timely toileting and incontinence care. Resident A and E were assessed for Bowel/Bladder Retraining and program established as indicated.2. All incontinent residents who depend on staff could be affected. Personal care observations were completed by a nurse unit manager on all residents identified as dependent on staff for toileting, utilizing their last MDS toileting code, to ensure that necessary services are provided for timely toileting and incontinence care. Any failure to provide timely toileting and incontinence care was reported to the DON for investigation. All residents identified as dependent on staff for toileting via their 1st MDS coding were assessed for Bowel/Bladder Retraining and program established as indicated.3. Bowel/Bladder Retraining programs were established on residents identified as dependent on staff for toileting as indicated. Assigned CNA's</p>	07/27/2013	

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	<p>and always incontinent of bladder. A review of the facility Quarterly Data Collection Tool, dated 05-29-13, indicated the resident was "confused, and needs physical prompting," in regard to bowel and bladder. The "comment" section indicated "LE [lower extremity] CVA [cerebral vascular accident] with limited mobility and depends on staff for toileting - 1-2."</p> <p>The resident's current plan of care, originally dated 09-13-12, indicated "genitourinary - poor control r/t [related to] cerebrovascular disease." An "approach" indicated "toilet AC [before meals], PC [after meals], HS [at bedtime] and PRN [as needed]."</p> <p>Observation on 06-26-13 at 11:25 a.m., Resident "A" was observed seated in his wheelchair at the table in the North Lounge, waiting for lunch. The resident remained in the North Lounge until 2:20 p.m., at which time a request was made to check the resident for incontinence.</p> <p>The Licensed Nurse #10 and CNA #8 transported the resident to the common bathroom. The resident was assisted with the use of a mechanical lift to an upright position, and as the resident was raised from being</p>		<p>were inserviced on each individual bowel/bladder retraining program. The nurse managers will complete personal care observations on 3 dependent residents weekly x 4, then 5 residents monthly to ensure necessary services are given for timely toileting and incontinence care. An inservice was held on 7/15/13 and 7/22/13 for all nursing staff on timely toileting and incontinence care for dependend residents.4. The DON or designee will complete a review of 6 residents with urinary incontinence, utilizing the Urinary Continence performance approval tool, every month x 3 months they quarterly. The results of the personal care observations, the Urinary Continence performance improvement tool and any investigationa will be submitted and discussed athe the QAPI meeting.Unit Managers responsible, DON to monitor and report to QAPI5. Date of Completion: 7/27/13</p>				

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	<p>seated in the wheelchair, the resident's sweatpants were saturated with urine which spanned from the waist band to lower thighs, and the groin area in the front of the sweatpants.</p> <p>2. The record for Resident "E" was reviewed on 06-27-13 at 10:25 a.m.</p> <p>Diagnoses included, but were not limited to, convulsions, lack of coordination, alcohol persistent dementia, paranoid schizophrenia, and depressive disorder. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS, dated 04-30-13, indicated the resident had severe cognitive impairment, and was incontinent of bowel and bladder. A review of the facility quarterly data collection tool, dated 04-28-13, indicated the resident was "dependent on staff. Doesn't voice need to void."</p> <p>Review of the resident's current plan of care originally data 08-18-10 indicated "bladder incontinence since encephalopathy." An approach to the "subject" instructed the nursing staff to "keep clean and dry."</p>			

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	<p>Observation on 06-26-13 at 11:35 a.m., Resident "E" was observed seated in a wheelchair and transported to the North Dining Room with the assistance of a CNA (Certified Nurses Aide). The resident remained seated at the table throughout the lunch period, until approximately 1:45 p.m., when the resident was observed being walked to a recliner. When interviewed if the resident had previously been toileted, CNA #8 indicated "no." With the assistance of a therapy staff member and CNA #8, the resident was ambulated to her room.</p> <p>With the assistance of CNA #8 and CNA #9, the nursing staff members removed the resident's slacks and brief, by moving the resident from side to side. The resident's incontinent brief was saturated with urine and loose stool.</p> <p>This Federal tag relates to Complaint IN00129915.</p> <p>3.1-38(a)(3)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation and interview, the facility failed to ensure a resident received the treatment and services in regard to pressure ulcers, in that when a resident had been identified with a pressure ulcer, the nursing staff failed to ensure the physician ordered treatment was in place and failed to ensure preventative measures were implemented for 1 of 3 residents reviewed for pressure ulcers in a sample of 7. (Resident "A").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-26-13 at 11:00 a.m.</p> <p>Diagnoses included, but were not limited to, dementia with behaviors, lack of coordination, congestive heart failure, altered mental status, and</p>	F000314	<p>1. Licensed Nurse #10 completed treatment and replaced dressing for Resident A after resident was toileted and laid down on 6/26/13. Treatment was changed on 6/27/13 to skin prep every shift due to difficulty getting dressing to stay in place. The ADON reviewed the plan of care to ensure that all preventative measures were appropriate and in place.2. Any resident with a wound has the potential to be affected. The DON reviewed the plan of care for all residents with pressure ulcers to ensure that treatments and preventative measures were appropriate. The DON completed personal care observations to ensure that all physician ordered treatments and preventative measures were in place on all residents with pressure ulcers.3. The pressure ulcer records were updated by the DON and ADON to reflect what days and shifts the ulcer treatments are to be completed</p>	07/27/2013

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	<p>atrial fibrillation. These diagnoses remained current at the time of the record review.</p> <p>The current monthly re-write for June 2013 indicated a physician order dated 05-25-13 which indicated "cleanse with wound cleanser, then apply duoderm every three day and as needed, measure with each dressing change."</p> <p>A review of the resident's MDS (Minimum Data Set) assessment, dated 05-30-13 indicated the resident was occasionally incontinent of bowel and always incontinent of bladder. In addition, the resident was noted to have a clinical assessment of a current pressure ulcer and received dressings, treatments and pressure reducing devices.</p> <p>A review of the facility Quarterly Data Collection Tool, dated 05-29-13, indicated the resident was assessed as "High Risk for pressure Ulcers due to diagnoses which included peripheral vascular disease, edema 2+, arterial ulcers and pressure to the right buttocks."</p> <p>Review of the current plan of care, originally dated 04-21-13, indicated "subject - skin, increased sedentary</p>		<p>and measured. The pressure ulcer records will be reviewed during the daily review by the DON, ADON or designee to ensure the treatment and measurements were completed and documented. Any pressure ulcer record that was not completed as indicated will then be followed up with a personal care observation to ensure the physician ordered treatment is in place. Failure to complete a treatment as ordered will be listed on a med error form and investigated by the DON. Failure to update the pressure ulcer form will be listed on the homework sheet for completion and follow up. The homework sheet will be initialed when completed and returned to the DON or designee whom will ensure the task was completed. Any task not completed on next schedule shift will be addressed by the supervisor to include additional training, coaching, and/or disciplinary action. The DON or designee will do random personal care observations on all residents with pressure ulcers weekly to ensure treatments and preventive measures are appropriate and in place. An inservice was completed on 7/15/13 and 7/22/13 for all nursing staff on the prevention and treatment of pressure ulcers.4. The DON or designee will complete the Pressure Sore Performance improvement tool</p>				

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	<p>related to need to elevate lower extremities."</p> <p>"Approaches" to this plan of care, dated 04-21-13 included "Duoderm left butt [buttocks] change every three days, Duoderm right butt - change every three days."</p> <p>An additional "approach" dated 05-25-13 indicated "apply duoderm to open areas on right buttocks and left buttocks change every three days and as needed. Measure with each dressing change."</p> <p>Review of the skin condition record, last documentation of the resident's buttocks indicated the resident continued to have excoriation to the right lower buttocks which measured 0.9 centimeters in length by .3 centimeters in width and was superficial in depth.</p> <p>The area to the left middle buttocks was also assessed as excoriation and measured 1.4 centimeters in length by .7 centimeters in width and was superficial in depth."</p> <p>Review of a subsequent plan of care, dated 05-09-13 indicated the nursing staff would "monitor nutrition and hydration, weigh the resident weekly,</p>		<p>monthly on every resident with a pressure ulcer. The results of the persoanal care observations, the Pressure Sore performance improvement tool and any invstigations will be submitted and discussed at the monthly QAPI meeting.Licensed staff responsible, ADON/DON to monitor and report toQAPI 5. Date of completion: 07/27/13</p>				

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	<p>assess labs as ordered, consultation by the dietician, the use of assistive devices to move and transfer as needed."</p> <p>Observation on 06-26-13 at 11:25 a.m., Resident "A" was observed seated in his wheelchair at the table in the North Lounge, waiting for lunch. The resident remained in the North Lounge until 2:20 p.m., at which time a request was made to check the resident for incontinence.</p> <p>The Licensed Nurse #10 and CNA #8 transported the resident to the common bathroom. The resident was assisted with the use of a mechanical lift to an upright position, and as the resident was raised from being seated in the wheelchair, the resident's sweatpants were saturated with urine which spanned from the waist band to lower thighs, and the groin area in the front of the sweatpants. The Licensed Nurse and CNA lowered the resident's sweatpants and removed the incontinent brief.</p> <p>During this observation the resident did not have the physician prescribed treatment to the excoriated area. Interview on 06-26-13 at 2:30 p.m., Licensed Nurse #10 verified the</p>			

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	<p>resident did not have the prescribed treatment in place.</p> <p>This Federal tag relates to Complaint IN00129915.</p> <p>3.1-40(a)(2)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation and interview, the facility failed to ensure appropriate incontinent care to prevent the possibility of urinary tract infection, in that when a dependent resident was incontinent of bowel and bladder the nursing staff failed to provide pericare in a manner to prevent possible urinary tract infections for 1 of 3 dependent residents reviewed in a sample of 7. (Resident "E").</p> <p>Findings include:</p> <p>The record for Resident "E" was reviewed on 06-27-13 at 10:25 a.m. Diagnoses included but were not limited to convulsions, lack of coordination, alcohol persistent dementia, paranoid schizophrenia, and depressive disorder. These diagnoses remained current at the</p>	F000315	<p>1. Resident E was assessed by the ADON for signs and symptoms of a urinary tract infection on 6/27/13. CNA#8 was given a coaching plan, including four hours of education and return demonstrations on proper perineal care, handwashing and infection prevention on 7/22/13.2. Any resident dependent on staff for toileting could be affected. All residents identified dependent on staff for toileting, (utilizing their last MDS toileting code) were assessed for signs and symptoms of a urinary tract infection by the DON or designee on 7/24/13 and reported to the residents physician as indicated.3. All CNA's were inserviced on perineal care, handwashing and infection prevention on 7/22/13 and 7/29/13. The DON or designee will complete care observations on 10% of all residents per month to ensure perneal care was provided in a manner to preven the possibility</p>	07/27/2013

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	<p>time of the record review.</p> <p>A review of the resident's MDS (Minimum Data Set) assessment, dated 04-30-13, indicated the resident had severe cognitive impairment, and was incontinent of bowel and bladder. A review of the facility quarterly data collection tool, dated 04-28-13, indicated the resident was "dependent on staff. Doesn't voice need to void."</p> <p>Review of the resident's current plan of care originally data 08-18-10 indicated "bladder incontinence since encephalopathy." An approach to the "subject" instructed the nursing staff to "keep clean and dry."</p> <p>Observation on 06-26-13 at 11:35 a.m., Resident "E" was observed seated in a wheelchair and transported to the North Dining Room with the assistance of a CNA (Certified Nurses Aide). The resident remained seated at the table throughout the lunch period, until approximately 1:45 p.m., when the resident was observed being ambulated to a recliner. When interviewed if the resident had previously been toileted, CNA #8 indicated "no." When interviewed if the resident was incontinent, the CNA</p>		<p>of infection. The DON or designee will complete handwashing observations on 10% of all residents during perineal care observations per month to ensure hand washing is completed per policy. The DON will ensure that all full-time and part-time CNA's are observed providing perineal care and handwashing at least quarterly during care observations. Visual reminders for handwashing were placed in resident bathrooms to increase awareness and will remain in place for 3 months.4. The DON or designee will track urinary tract infections by CNA assignment on the infection control surveillance report to identify and trends and will investigate as indicate. The results of care observation including perineal care and handwashing. The Infection Control Surveillance Report will be submitted and discussed at the montly QAPI meeting.Nursing Staff responsible. DON to monitor and report to QAPI 5. Date of completion: 07/27/13</p>	

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	<p>indicated "yes she's dirty - I thought I smelled something." With the assistance of a therapy staff member and CNA #8, the resident was ambulated to her room.</p> <p>The CNA and therapist assisted the resident to bed, and the therapist exited the resident room and closed the door.</p> <p>CNA #8 donned gloves, wet washcloths and attempted to turn the resident to her left side. The resident was unable to assist or maintain position for incontinent care and the CNA indicated "I have to get some help and I have to get some bags." The CNA removed the gloves and exited the resident's room.</p> <p>At 2:07 p.m. CNA #8 returned to the resident's room with CNA #9.</p> <p>CNA #9 and CNA #8 donned gloves. Both CNA's assisted the resident to her left side and pulled part of the resident's slacks down, and unfastened the side tabs of the incontinent brief. The resident was then assisted to the right side and the slacks were further removed as well as the incontinent brief. The brief was saturated with urine and loose stool. The soiled slacks and</p>						

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	<p>incontinent brief were placed in plastic bags. The resident was positioned on her back.</p> <p>CNA #8 picked up a wet wash cloth and washed back and forth and then in an up and down motion across the resident's periarea. CNA #8 placed the soiled washcloth in the plastic bag. During this observation, CNA #9 prompted CNA #8 to "wash front to back."</p> <p>The resident's was turned to her right side. CNA #8 continued to provide incontinent care in a back and forth motion, turning the wash cloth over, and over, cleaning the stool from the resident's buttocks and pericare, rather than using a new wet wash cloth to complete pericare for the resident. Again CNA #9 again prompted CNA #8 to wash from "front to back." CNA #8 placed the soiled washcloth into the plastic bag.</p> <p>Upon completion of pericare, CNA #8 removed her gloves and with the assistance of CNA #9 placed a clean incontinent brief on the resident. CNA #9 removed her gloves, entered the resident bathroom, washed her hands, exited the resident room, and closed the door.</p>			

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	<p>CNA #8 continued to make the resident comfortable with placing a sheet over her, and then picked up the bags of soiled linen, clothes and incontinent brief, opened the resident door and exited the room. No handwashing was observed.</p> <p>During a subsequent observation on 06-27-13 at 1:15 p.m., Resident "E" was observed seated in her wheelchair in the North Lounge. The resident fidgeted in the wheelchair and tried to raise self up off of buttocks. CNA's #12 and #13 ambulated the resident to the common bathroom on the north hall and indicated they were going to toilet the resident. As the CNA's removed the resident's slacks and incontinent brief, the resident became incontinent of stool. The resident was placed on the toilet. When the CNA's determined the resident had completed her bowel movement, CNA #13, took a piece of toilet paper and "wiped" the resident's rectal area, placed a clean incontinent brief on the resident, and dressed the resident in clean slacks.</p> <p>During the Exit conference on 06-27-13 at 3:00 p.m., the Assistant Director of Nurses indicated the CNA's should have performed complete pericare for the resident.</p>			

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	<p>Review of facility policy on 06-27-13 at 12:50 p.m., titled "Incontinent Resident Care," dated 01-05-12, indicated the following:</p> <p>"Policy - Incontinent residents will be cared for by nursing personnel to ensure adequate skin care, control odor, and provide personnel hygiene...</p> <p>Procedure - 1. Identify resident. 2. Explain procedure to resident and provide privacy. 3. Assemble equipment: linen as needed, cleansing agent, lotion, wash basin, toilet tissue, disposable gloves. 4. Wash hands. 5. Put on disposable gloves. 6. Remove soiled clothing. 7. Wash, rinse and dry the skin, being certain to expose all skin surfaces which are soiled. On female residents, wash from front to back to avoid urethral or vaginal contamination. 8. Apply lotion and dry [this helps prevent pressure sores]. 9. Replace the resident's gown or other clothing as indicated. 10. Leave the resident comfortable with signal cord in reach. 11. Dispose of linen per exposure control policy. 12. Wash hands...."</p> <p>Review of facility policy on 06-27-13</p>			

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	<p>at 12:50 p.m., titled "Handwashing Technique," dated 01-03-12, indicated the following:</p> <p>"Policy - All personnel will wash hands to remove dirt, organic material and transient microorganisms to prevent the spread of infections. Hands must be washed: After contact with blood/body fluids, in between resident contacts, before clean procedure, after contact with contaminated items or surfaces, after removal of gloves, after personal use of the toilet, after covering a cough or sneeze, before eating, drinking or smoking. Proper handwashing between residents is also important in preventing the spread of infection. Therefore, personnel having contact with residents shall stress the importance of handwashing and encourage the residents to wash their hands properly."</p> <p>This Federal tag relates to Complaint IN00129915.</p> <p>3.1-41(a)(2)</p>				

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F000425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview the facility failed to ensure periodic reconciliation of controlled medications, in that when the facility had residents who had physician orders for as needed controlled pain medication, the nursing staff and pharmacy failed to perform random reconciliation of the medications for 2 of 2 residents reviewed for controlled medications and reconciliation in a sample of 7. This deficient practice had the potential to effect all cognitively impaired residents. (Residents "A" and "G").</p>	F000425	. The MAR and conrolled Substance Records for residents A&G were reviewed on 6/27/13 for indications that prn narcotic analgesics were being given as a chemical restraint or for staff convenience. As a result of this review, Licensed Nurse #14 was suspended pending investigation. During the interview njurse #14 admitted to giving prn narcotic analgesics to residents A&G for purposes other than to treat the medical systpton as was ordered by the physician. Nurse #14 was terminated upon completion of the investigation. on 6/24/13.2. Any cognitively impaired resident with an order	07/27/2013			

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	<p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-26-13 at 11:00 a.m. Diagnoses included but were not limited to dementia with behaviors, lack of coordination, congestive heart failure, altered mental status, and atrial fibrillation. These diagnoses remained current at the time of the record review.</p> <p>Review of the current Physician rewrite for the month of June 2013, indicated the resident had physician orders, originally dated 03-04-13 for Tramadol (an opoid analgesic controlled substance medication) 50 mg (milligrams) by mouth two times a day as needed for pain. This re-write also indicated the resident had Tylenol (an analgesic) 650 mg by mouth every four hours as needed for pain.</p> <p>The resident's MDS (Minimum Data Set) assessment, dated 05-30-13 indicated the resident received pain medication and staff assessment was needed to address the resident's vocal complaints or facial expressions of pain.</p> <p>The current plan of care, originally dated, 09-13-12 indicated "subject -</p>		<p>for controlled substances could have the potential to be affected. The June 2013 MAR and Controlled Substance Records for all cognitively impaired residents receiving prn narcotic analgesics were reviewed by the pharmacist on 7/10/13 and 7/11/13 for indications they were being given as a chemical restraint or for staff convenience. There was no indications any nurse had used controlled substances improperly, except Nurse#14.3. The MAR and Contolled Substance Records for all cognitively impaired residents on prn narcotic analgesics will be reviewed weekly by the unit managers for indications that they were being accurately administerd and document to meet the needs of each resident. Any inaccuracies will be reported to the DON for investigation. The unit managers completed a medication pass review on all licensed nurses and QMA's. The unit managers will complete three randome medication pass reviews every month x 12 months, utilizing the Review of Medication Pass performance improvement tool, ensuring that all licesed nurses and QMA's are reviewed at least quarterly. An inservice was complete for licensed nurses and QMA's on 7/15/13 and 7/22/13 on the accurate administration and documentaion of prn controlled substances.4. The pharmacist is to conduct a monthly audit of the</p>				

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	<p>pain interventions." An approach to this "subject" included Tramadol 50 mg by mouth BID (two times a day) PRN (as needed) for pain."</p> <p>A Quarterly Data Collection Tool, dated 05-29-13 indicated when the nurse asked the resident to "rate" his pain, the nurse documented the resident "just looked at writer non sensical 'I love you.'" "Current pain treatment: Tramadol PRN." This Pain assessment checklist of non-verbal indicated - scale B, was a handwritten notation "No s/sx [signs or symptoms]."</p> <p>The resident "Controlled Substances Record" was reviewed. During this review Licensed Nurse #14 dispensed the medication to the resident on the following dates and times:</p> <p>April 19 at 4:00 p.m., April 22 at 4:00 p.m., April 23 at 4:00 p.m., April 25 at 4:00 p.m., April 26 at 4:00 p.m., April 27 at 4:00 p.m., and April 28 at 4:00 p.m.</p> <p>May 10 at 6:00 p.m., May 11 at 6:00 p.m., May 12 at 6:00 p.m., May 20 at 7:00 p.m., May 21 at 7:00 p.m., May 22 at 7:00 p.m., May 23 at 6:00 p.m., May 24 at 7:00 p.m., May 25 at 7:00 p.m., and May 26 at 7:00 p.m.</p>		<p>MAR and Controlled Substance Records for the previous month on allo cognitively imparied resident receiving prn narcotic analgesics for any indication of them being used as a chemical restraint or for staff convenience. Any indications will be reported to the DON for investigaiton. The results of the pharmacist audit and any investigations will be submitted anddiscussed at the montly QAPI meeting.Licensed Staff responsible. Pharmacist and DON to monitor and report to QAPI.5. Date of Completion: 07/27/13</p>	

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	<p>Review of the Medication Record for May 2013 notes for the "reason" Licensed Nurse #14 gave the resident the medication indicated "c/o [complaints of] generalized pain - no relief with repositioning - helpful [time indicated]." This notation was repeated for each entry. However the "notation" section lacked documentation the medication was dispensed on May 12 or May 26, 2013.</p> <p>June 3 at 7:00 p.m., June 4 at 8:00 p.m., June 5 at 8:00 p.m., June 6 at 8:00 p.m., June 7 at 9:00 p.m., June 8 at 9:00 p.m., June 9 at 9:00 p.m., and June 15 at 9:00 p.m.</p> <p>Review of the Medication Record for June 2013 notes for the "reason" the Licensed Nurse #14 medication was given to the resident indicated, "c/o general pain - no relief with repositioning - helpful at [time indicated]" for each entry. However further review of this record indicated the medication was also dispensed on June 9, 15, and 16, 2013 without documentation of the "reason" the medication was given to the resident, and the dosage given on June 16th, according to the Controlled Substances Record, was not</p>			

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	<p>recorded.</p> <p>2. The record for Resident ""G" was reviewed on 06-27-13 at 12:00 p.m. Diagnoses included but were not limited to dementia with behaviors, hypertension, anxiety, cardiomyopathy and vascular dementia. These diagnoses remained current at the time of the record review.</p> <p>The current Physician Re-write for June 2013, indicated the resident had physician orders, dated 05-14-13 for Norco (a narcotic analgesic) 5/325 mg three times a day as needed for pain. This re-write also indicated the resident had Tylenol (an analgesic) 650 mg by mouth three times a day for pain.</p> <p>The resident's MDS, dated 05-30-13 indicated the resident had orders for PRN pain medication and that "pain was present but (resident) unable to answer."</p> <p>Review of the resident's current plan of care, originally dated 01-11-12 indicated "Has c/o pain all over for years." An approach to this "subject" indicated the resident had a current physician order for the narcotic analgesic.</p>						

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	<p>A Quarterly Data Collection Tool, dated 05-14-13 indicated the nurse was unable to rate the resident's pain, "couldn't respond to pain question, just looked at writer and asked 'Do you know who I am.' Current pain treatment: Norco PRN." This Pain assessment checklist of non-verbal indicated - scale B, was a handwritten notation "No s/sx [signs or symptoms] Hospice, vascular dementia."</p> <p>A review of the "Controlled Substances Record," indicated Licensed Nurse #14 dispensed the medication to the resident on the following dates and times:</p> <p>May 20 at 6 p.m., May 21 at 6 p.m., May 22 at 6 p.m., May 23 at 6 p.m., May 24 at 6 p.m., May 25 at 6 p.m., and May 26 at 6 p.m.</p> <p>The reverse side of the Administration Record indicated Licensed Nurse #14 "reason" the resident required the medication was "generalized pain - no relief with repositioning - helpful at (time indicated)" for each entry.</p> <p>The reverse side of the administration record for June 2013, Licensed Nurse #14 indicated the "reason" the resident required the medication was</p>			

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	<p>"generalized pain - no relief with repositioning - helpful at (time indicated)," for each entry. In addition the record lacked documentation of the June 9th dose, and lacked documentation for the "reason" for the June 16th dose.</p> <p>Review of the facility policy on 06-27-13 at 12:50 p.m., titled "Pain Assessment," and dated 01-04-12 indicated the following:</p> <p>"Policy - Residents will be assessed for pain upon admission, readmission, quarterly, annually, upon significant change, when a resident experiences a new onset of pain or experiencing uncontrolled pain."</p> <p>"Procedure - A weekly review of pain will be completed on the Weekly Progress Notes. A Pain Flow Record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they have pain."</p> <p>"Record the following: 1. Date and time, 2 Site and location, 3. Type of pain, 4. Intensity, 5. Precipitating/aggravating, 6. Interventions - non-med [medication]/medication, 7. Intensity</p>			

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	<p>of pain after intervention, 8. Side effects, and 9. Initials."</p> <p>Interview on 06-27-13 at 1:20 p.m. the Assistant Director of Nurses indicated, "We don't have the pain flow sheets or progress notes for [names of Resident's "A" and "G"].</p> <p>During the Exit conference on 06-27-13 at 3:00 p.m., the Administrator indicated it was the responsibility of the Pharmacy Tech. (technician) to recognize and monitor the controlled drugs.</p> <p>This Federal tag relates to Complaint IN00129915.</p> <p>3.1-25(b)(3) 3.1-25(e)(2) 3.1-25(e)(3)</p>			

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F000441 SS=D	<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 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 and interview, the facility failed to ensure</p>	F000441	1. Resident E was assessed by the ADON for signs and	07/27/2013			

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	<p>appropriate incontinent care to prevent the possibility of urinary tract infection, in that when a dependent resident was incontinent of bowel and bladder the nursing staff failed to provide proper incontinent care for 1 of 3 dependent residents reviewed in a sample of 7. (Resident "E").</p> <p>Findings include:</p> <p>The record for Resident "E" was reviewed on 06-27-13 at 10:25 a.m. Diagnoses included but were not limited to convulsions, lack of coordination, alcohol persistent dementia, paranoid schizophrenia, and depressive disorder. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS (Minimum Data Set) assessment, dated 04-30-13, indicated the resident had severe cognitive impairment, and was incontinent of bowel and bladder. A review of the facility quarterly data collection tool, dated 04-28-13, indicated the resident was "dependent on staff. Doesn't voice need to void."</p> <p>Review of the resident's current plan of care originally data 08-18-10 indicated "bladder incontinence since</p>		<p>symptoms of a urinary tract infection on 6/27/13. CNA#8 was given a coaching plan, including four hours of education and return demonstration on proper perineal care, handwashing and infection prevention on 7/23/13.2. Any resident that is dependent on staff for toileting has the potential to be affected. All residents identified as dependent on staff for toileting (utilizing their last MDS toileting code) were assessed for signs and symptoms of a urinary tract infection by the DON or designee on 7/24/13 and reported to the resident's physician as indicated³. All CNA's were inserviced on perineal care, handwashing and infection prevention on 7/22/13 & 7/29/13. The DON or designee will complete care observations on 10% of all residents per month to ensure perineal care was provided in a manner to prevent the possibility of infection. The DON or designee will complete handwashing observations on 10% of all residents during perineal care observations per month to ensure hand washing is completed per policy. The DON will ensure that all full-time and part-time CNA's are observed providing perineal care and handwashing at least quarterly during care observations. Visual reminders for handwashing were placed in resident bathrooms to increase awareness and will</p>				

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	<p>encephalopathy." An approach to the "subject" instructed the nursing staff to "keep clean and dry."</p> <p>Observation on 06-26-13 at 11:35 a.m., Resident "E" was observed seated in a wheelchair and transported to the North Dining Room with the assistance of a CNA (Certified Nurses Aide). The resident remained seated at the table throughout the lunch period, until approximately 1:45 p.m., when the resident was observed being ambulated to a recliner. When interviewed if the resident had previously been toileted, CNA #8 indicated "no." When interviewed if the resident was incontinent, the CNA indicated "yes she's dirty - I thought I smelled something." With the assistance of a therapy staff member and CNA #8, the resident was ambulated to her room.</p> <p>The CNA and therapist assisted the resident to bed, and the therapist exited the resident room and closed the door.</p> <p>CNA #8 donned gloves, wet washcloths and attempted to turn the resident to her left side. The resident was unable to assist or maintain position for incontinent care and the</p>		<p>remain in place for 3 months.5. The DON or designee will track urinary tract infections by CNA assignment on the infection control surveillance report to identify any trends and will investigate as indicated. The results of the care observations including perineal care and handwashing and the infection control surveillance report will be submitted and discussed at the monthly QAPI meeting. ADON responsible for training, DON to monitor and report to QAPI for review.6. Date of completion: 07/27/13</p>	

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NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>CNA indicated "I have to get some help and I have to get some bags." The CNA removed the gloves and exited the resident's room.</p> <p>At 2:07 p.m. CNA #8 returned to the resident's room with CNA #9.</p> <p>CNA #9 and CNA #8 donned gloves. Both CNA's assisted the resident to her left side and pulled part of the resident's slacks down, and unfastened the side tabs of the incontinent brief. The resident was then assisted to the right side and the slacks were further removed as well as the incontinent brief. The brief was saturated with urine and loose stool. The soiled slacks and incontinent brief were placed in plastic bags. The resident was positioned on her back.</p> <p>CNA #8 picked up a wet wash cloth and washed back and forth and then in an up and down motion across the resident's periarea. CNA #8 placed the soiled washcloth in the plastic bag. During this observation, CNA #9 prompted CNA #8 to "wash front to back."</p> <p>The resident's was turned to her right side. CNA #8 continued to provide incontinent care in a back and forth</p>			

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	<p>motion, turning the wash cloth over, and over, cleaning the stool from the resident's buttocks and pericare, rather than provide a new wet wash cloth to complete pericare for the resident. Again CNA #9 again prompted CNA #8 to wash from "front to back." CNA #8 placed the soiled washcloth into the plastic bag.</p> <p>Upon completion of pericare, CNA #8 removed her gloves and with the assistance of CNA #9 placed a clean incontinent brief on the resident. CNA #9 removed her gloves, entered the resident bathroom, washed her hands, exited the resident room, and closed the door.</p> <p>CNA #8 continued to make the resident comfortable with placing a sheet over her, and then picked up the bags of soiled linen, clothes and incontinent brief. opened the resident door and exited the room.</p> <p>During a subsequent observation on 06-27-13 at 1:15 p.m., Resident "E" was observed seated in her wheelchair in the North Lounge. The resident fidgeted in the wheelchair and tried to raise self up off of buttocks. CNA's #12 and #13 ambulated the resident to the common bathroom on the north hall and indicated they were</p>			

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	<p>going to toilet the resident. As the CNA's removed the resident's slacks and incontinent brief, the resident became incontinent of stool. The resident was placed on the toilet. When the CNA's determined the resident had completed her bowel movement, CNA #13, took a piece of toilet paper and "wiped" the resident's rectal area, placed a clean incontinent brief on the resident, and dressed the resident in clean slacks.</p> <p>During the Exit conference on 06-27-13 at 3:00 p.m., the Assistant Director of Nurses indicated the CNA's should have performed complete pericare for the resident.</p> <p>Review of facility policy on 06-27-13 at 12:50 p.m., titled "Incontinent Resident Care," dated 01-05-12, indicated the following:</p> <p>"Policy - Incontinent residents will be cared for by nursing personnel to ensure adequate skin care, control odor, and provide personnel hygiene."</p> <p>"Procedure - 1. Identify resident. 2. Explain procedure to resident and provide privacy. 3. Assemble equipment: linen as needed, cleansing agent, lotion, wash basin, toilet tissue, disposable gloves. 4.</p>						

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	<p>Wash hands. 5. Put on disposable gloves. 6. Remove soiled clothing. 7. Wash, rinse and dry the skin, being certain to expose all skin surfaces which are soiled. On female residents, wash from front to back to avoid urethral or vaginal contamination. 8. Apply lotion and dry [this helps prevent pressure sores]. 9. Replace the resident's gown or other clothing as indicated. 10. Leave the resident comfortable with signal cord in reach. 11. Dispose of linen per exposure control policy. 12. Wash hands."</p> <p>Review of facility policy on 06-27-13 at 12:50 p.m., titled "Handwashing Technique," dated 01-03-12, indicated the following:</p> <p>"Policy - All personnel will wash hands to remove dirt, organic material and transient microorganisms to prevent the spread of infections. Hands must be washed: After contact with blood/body fluids, in between resident contacts, before clean procedure, after contact with contaminated items or surfaces, after removal of gloves, after personal use of the toilet, after covering a cough or sneeze, before eating, drinking or smoking. Proper handwashing between residents is also important in</p>			

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	<p>preventing the spread of infection. Therefore, personnel having contact with residents shall stress the importance of handwashing and encourage the residents to wash their hands properly."</p> <p>This Federal tag relates to Complaint IN00129915.</p> <p>3.1-18(a) 3.1-18(l)</p>			