

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/25/2013
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NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
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F000000	<p>This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00123837.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00126434.</p> <p>Complaint #IN00123837 Substantiated. Federal/state deficiencies related to the allegations are cited at F226.</p> <p>Survey dates: March 18, 19, 20, 21, 22, and 25, 2013</p> <p>Facility number: 003075 Provider number: 155695 AIM number: 200364160</p> <p>Survey Team: Shelly Vice, RN - TL Shauna Carlson, RN Julie Baumgartner, RN</p> <p>Census bed type: SNF/NF : 76 Total: 76</p> <p>Census payor type: Medicare: 5</p>	F000000	<p>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. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after April 24, 2013.</p>	

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

TITLE

(X6) DATE

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

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	<p>Medicaid: 69 Private: 2 Total: 76</p> <p>Residential Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 3, 2013, by Brenda Meredith, R.N.</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>1) Based on interview and record review, the facility failed to report the loss of a 30-day supply of a Multiple Sclerosis (MS) medication (Ampyra) for Resident B. This affected 1 of 2 residents sampled that receive medications from an out of facility contracted pharmacy provider. (Resident B)</p> <p>2) Based on interview and record review, the facility failed to ensure that 1 of 8 employees knew the correct procedure of immediately notifying the administrator in a situation identified of potentially abusive. (Employee #2)</p> <p>3) Based on interview and record review, the facility failed to ensure 1 of 8 employees knew the types of abuse and neglect. (Employee #3)</p> <p>Findings include:</p> <p>1) On 1/18/13 at 11:00 a.m. an interview was conducted with a surveyor for the Division of Aging</p>	F000226	<p>F226 – Develop/Implement Abuse/Neglect, etc Policies</p> <p>It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <p><i>Resident B</i> –physician and family has been updated regarding this resident’s current status. This resident’s medication was replaced she has been receiving the medication as ordered. This resident has had no complaints of “shakiness/tremors” or other negative side effects. Nursing staff has been in-serviced on placing medications into medication cart upon receiving from resident.</p> <p><i>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:</i></p> <p>All residents are at risk to be affected by this finding. Resident</p>	04/24/2013			

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	<p>which indicated a discussion had occurred between the Division of Aging and Resident B. The representative for the Division of Aging indicated Resident B had ordered Multiple Sclerosis medication, Ampyra 10 mg (milligram) tablets, and had them delivered by (name of delivery service) to the facility. The representative for the Division of Aging also indicated "...the facility had received the medications by [name of delivery service] and had lost the medications...the medicine came up missing...Employee #14 had met with the Resident, yet had been unable to locate the missing medications...ED [Executive Director] and DNS [Director of Nursing Service] were following up on this..." It was also indicated, the Resident B had indicated that a side effect of, "... increased tremors had occurred during the span of time there was no medicine..." for the MS.</p> <p>On 3/20/13 at 2:05 p.m., record review was made of the clinical record for Resident B which indicated that the diagnoses for Resident B included but were not limited to "...Multiple Sclerosis, Hemiplegia/hemiparesis, Asthma, Arthropathy...." Review indicated that the medication, Ampyra 10 mg tablet, was prescribed twice a</p>		<p>and family interviews were conducted per CQI Abuse Questionnaire devised by CMS to ensure there were no other concerns related to this finding. There were no noted concerns expressed during these interviews. The ED, DNS/designee will be responsible for conducting random facility tours (including after hours and weekends) and interviews with staff regarding Abuse, Prohibition, Reporting and Investigation. Nursing staff has been in-serviced on placing medications into medication cart upon receiving from resident.</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: All staff in-services will be conducted on or before 4/23/13. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act. All staff will be re-educated regarding the various types of abuse, the correct procedure for responding to and timely reporting of any alleged or actual abuse situation and misappropriation of resident property. Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the ED and/or DNS. The facility will immediately initiate a full</p>				

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	<p>day for management of the symptoms of the determination of muscular dexterity in the progression of the disease Multiple Sclerosis. Further review indicated that during the month of December 2012, from the dates of 12/12/2011 until 12/26/12, Ampyra was not available and was not provided for administration. Review of the medication administration record (MAR) indicated that the medication was not administered, and the medication was, "unavailable." A Medical Doctor, a Neurologist, a local pharmacy and an out-of-town pharmacy had been contacted for follow-up with the unavailability of this medication. The clinical record also indicated that side effects were monitored, using the 'HOT Documentation' procedure for monitoring an acute situation of concern by the facility.</p> <p>On 3/20/13 at 2:06 p.m., an interview was conducted with Employee #5 and Employee #18 which indicated both were aware that Resident B was taking a medication that was delivered by mail for Multiple Sclerosis and that the facility used (name of pharmacy) for its pharmacy services. Resident B utilized an out of facility pharmacy for obtaining medications.</p>		<p>investigation as well as ensure notification to the MD, family, ISDH and other agencies as outlined in the facility policy. The ED, DNS/designee will be responsible for conducting this in-service. The ED, DNS/designee will be responsible for conducting facility interviews with staff daily, on all shifts, regarding Abuse Prohibition, Reporting and Investigation until compliance is achieved.</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: The ED, DNS/designee will be responsible for completion of the CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly for 4 weeks then monthly for 6 months to monitor for ongoing compliance of this corrective action. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date: 4/24/13.</p>				

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	<p>On 3/20/13 at 2:10 p.m., an interview and record review of Resident B's clinical medical record was conducted with the DNS which indicated "... [Resident B's name] who uses a pharmacy [Name of Pharmacy] for only her MS drug..." The DNS indicated that there had not been problems getting Resident B's medicines ordered and delivered and that Resident B is seen by, "...a neurologist..." and there had not been any problems with re-ordering medications or having access to the MS medications. The DNS also indicated that the POS (physician order sheet) are reviewed several times prior to placing on charts for accuracy, the POS's were updated and corrected and audited for incorrectness: the triplicate form was then sent to the pharmacy for corrections to be made, and that a change of pharmacies had been made yet this had not affected the provision of medications for Resident B.</p> <p>On 3/21/13 at 3:00 p.m., interview with Employee #14 indicated that there had been no report of missing medications for Resident B.</p> <p>On 3/21/13 at 3:45 p.m., interview</p>			

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	<p>with the Administrator indicated the facility had no record for a reportable incident for Resident B.</p> <p>On 3/21/13 at 4:00 p.m., an interview with the DNS indicated "... a package of medicine, Ampyra was delivered by [Name of delivery service] to the resident B who gave the package of medication to a CNA and told her it was her medicine for her MS. The CNA then gave the package to the unit nurse, who then placed it into the medication room because it [the medicine package] could be locked up this way...." When the staff went to get the box, it wasn't there "...we [the facility] looked everywhere for the box and we could not find it... we called local pharmacies to replace the medication that was lost, and we could not get a local pharmacy to replace this particular medicine because of a special license a pharmacy has to possess to fill a prescription for this medicine, so, we were unable to refill the medicine...." An internal investigation by the DNS was conducted, yet, there was not a record of reporting the substantiated incident of the loss of Resident B's mail delivered Multiple Sclerosis medication delivered to the facility.</p> <p>On 3/21/13 at 4:05 p.m., an interview</p>			

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	<p>with the DNS indicated "We do not have a policy or procedure for these...we have not made a policy or procedure for our facility to prevent this again... we did inservice the nursing staff on how to handle a mail delivery of medications again...I can tell you, we did not report this as an allegation of neglect... we did not think of this as an act of neglect... we do not know what happened to the box of medications that was delivered to Resident B...the nurse who locked them up was interviewed and we cannot know what happened to them... this was a unusual thing...we do not normally have medications mail delivered by [Name of delivery service]...."</p> <p>On 3/21/13 at 4:45 p.m., a record review was conducted on the Policy and Procedure titled, "Unusual Occurrences for Residents and Visitors" provided by the Administrator which indicated "...Each facility has a fully functioning Risk management Program that includes a Risk Management protocol for the handling and processing of resident and visitor unusual events occurring within the facility... Each facility maintains the risk management Policy and Procedure and employees must reference them to ensure compliance</p>			

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	<p>with corporate policy...Definition of Unusual Occurrence/Event. An unusual occurrence/event is defined as any happening not consistent with the routine operation of the nursing facility...or loss...of property...."</p> <p>On 3/21/13 at 5:00 p.m. a record review was made of the procedure of refilling medications provided by the DNS which indicated "...uniform system for ordering medications from the pharmacy, and to ensure residents receive medications in a timely manner..." This procedure was noted to be developed by, "...[Name of Pharmacy] Long Term Care Pharmacy Policy and Procedure Manual...Revised 7/2011...Page 16 of 157...." This Policy and Procedure did not include information in regards to using a mail delivery for Resident B. Resident B does not use the [Name of Pharmacy] in this policy.</p> <p>On 3/21/13 at 5:05 p.m., an interview with the DNS indicated the facility did not have a policy and procedure on how to handle the refilling of medications that are being filled by an outside pharmacy service.</p> <p>On 3/25/13 at 10:30 a.m., an interview with Resident B indicated "...My medicine, Ampyra, I order and</p>						

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	<p>keep track of it...I ordered it myself because of privacy, I ordered it, got it in and someone put it into the medication room, and then...they couldn't find it. (Doctors name) prescribed it for me and the nurse isn't here any longer that put it in the med room...My doctor and I were more concerned about the person who may have taken the medicine, because this kind of medicine could really, really hurt someone if they were to take it...I was shakier than usual...I take the medicine... it's suppose to help me walk, yet I'm not walking any longer yet it does help my shakiness and I was real shaky when I didn't have the medicine...my private insurance finally paid for a 2nd prescription from my neurologist...I was off of my medicine for a good two weeks...it's an expensive medicine and if I didn't have health insurance, there is no way I could afford my medicines for the MS...the facility didn't pay for the 2nd order, my insurance did...I did talk to Employee #14 and the Administrator about this when it happened, they both knew what was going on with it all...."</p> <p>2) On 3/19/13 at 9:30 a.m., a review was made of the facility's policy and procedure for Abuse Prohibition, Reporting and Investigation which</p>			

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	<p>indicated "...5. All abuse allegations/abuse must be reported to the Executive Director immediately...6....The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations...."</p> <p>On 3/12/13 at 10:00 a.m., interview with employee #2 indicated "...after I know that the resident is safe, I'd investigate to see what was really going on... if it wasn't too bad, I'd just have a talk with them and maybe the resident... and then I'd just let it rest...or, if I felt it was really bad...I'd tell my supervisor...." Employee #2 indicated this was not the facility's policy and procedure to investigate the abuse allegation but indicated "...when we [staff] come upon abuse, we're to report it directly to the Executive Director...."</p> <p>3) On 3/8/13 at 11:55 a.m., a review was made of the facility's policy and procedure for Abuse Prohibition, Reporting and Investigation which indicated "... Definition of abuse...Physical abuse... verbal abuse...sexual abuse... mental abuse... neglect and Misappropriation of Resident Funds or Property..."</p>						

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	<p>On 3/19/13 at 9:35 a.m., interview with employee #3 indicated "...the kinds of abuse...? Well, it could be anything you know... it could be in how I might talk to a resident... yeah, I'm really not sure...."</p> <p>This federal tag relates to Complaint #IN00123837.</p> <p>3.1-28(a) 3.1-28(c)</p>				

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F000253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to provide a safe and clean environment related to common lounge areas, resident rooms, clean and dirty utility rooms, common bathing rooms, and linen closets. This deficiency had the potential to affect 76 of 76 residents.</p> <p>Findings include:</p> <p>On 3-25-2013, during the environmental tour accompanied by the maintenance Manager and the Housekeeping Supervisor the following was noted:</p> <ol style="list-style-type: none"> At 8:49 AM, an observation of the front lounge carpet revealed stains. At 8:49 AM, an interview with Employee # 21 indicated the carpet is steam cleaned monthly. Employee #21 indicated that she can not remember when the carpeting was last replaced and "...it's been there as long as I've worked here...." At 9:05 AM, an observation of room 116 revealed scuffed walls with 	F000253	<p>F253 – Housekeeping/Maintenance Services</p> <p>It is the practice of this provider to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>Front Lounge Carpet</i> – has been cleaned <i>Room 116</i> – the far wall has been repaired and repainted <i>Common Bathing Room on Heritage Hall</i> – the sink has been repaired, the water temperatures are within acceptable parameters, the tiles behind the toilet have been repaired and the floor has been scrubbed and cleaned <i>Room 118</i> – has been deep cleaned, the door magnet has been repaired and the toilet seat has been replaced <i>Room 216</i> – the bathroom sink has been replaced <i>Room 308</i> – the wall has been repaired and repainted</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	04/24/2013	

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	<p>large gouges on the far wall. It appeared to be from the headboards of the bed having hit against the wall. An interview with Resident #23, residing in the room indicated "...staff push the wheelchairs into the wall at night...."</p> <p>4. At 9:08 AM, an observation of the common bathing room on the Heritage Hall revealed that the sink was not draining. The temperature of the water coming out of the shower was noted to be 100 degrees by using the Maintenance Managers thermometer. An observation of the tiles behind the toilet were coming loose and the floor tiles were slippery upon walking on them.</p> <p>5. At 9:16 AM, an observation of room 118 revealed trash on the floor and that the back of the door was missing the magnet that the door attached to to allow the door to remain open. Due to the missing magnet, the residents door swung closed on its own. The toilet in the bathroom was observed to have rust on the hinged connection of the toilet seat to the toilet.</p> <p>6. At 9:20 AM, an observation of room 216 revealed a sink had came away from the wall and was being held up only by two metal legs.</p>		<p>identified and what corrective action(s) will be taken: All residents have the potential to be affected by this finding. All resident rooms, bathrooms, lounge areas and common bathing areas have been observed for items such as those identified in this finding. Cleaning and repairs were completed where needed. In addition, the facility will conduct Environmental Inspections no less than five times per week. These Environmental Inspections will include inspections/observations of resident rooms, bathrooms, lounge areas, common bathing areas and linen closets by the Housekeeping Supervisor/designee. Any needed environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Requests daily to ensure all necessary repairs and corrections have been completed. A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 4/23/13. This in-service will include review of the facility policy related to notification to the Maintenance Department and/or Housekeeping Department for housekeeping issues, repairs or</p>	

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	7. At 9:28 AM, an observation of room 308 revealed scuffed and chipped paint on the walls. 3.1-19(f)		<p>maintenance needs and the importance of maintaining a safe, functional/sanitary/comfortable environment.</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>A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 4/23/13. This in-service will include review of the facility policy related to notification to the Maintenance Department and/or Housekeeping Department for housekeeping issues, repairs or maintenance needs and the importance of maintaining a safe, functional/sanitary/comfortable environment. Environmental Inspections will be completed no less than five times per week. These Environmental Inspections will include inspections/observations of resident rooms, bathrooms, lounge areas, common bathing areas and linen closets. Any needed environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request daily to ensure all necessary repairs and</p>		

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			<p>corrections have been completed.</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: To ensure ongoing compliance with this corrective action and to ensure the environment is safe/functional/sanitary and comfortable, the ED/DNS/designee will be responsible for completion of CQI tool titled Quality Control Inspection - Housekeeping no less than five times per week for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date: 4/24/13.</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to provided supervision of 4 residents in relation to their respective wandering care plans. This affected 4 of 4 residents sampled for lack of supervision. (Residents #99, #31, #83, and #47)</p> <p>Findings included:</p> <p>1) On 3/21/13 through 3/22/13 during the survey, Resident #99 was observed to be a dependent resident with functional capacity of extensive assistance in all areas of care. Resident #99 was medically functioning at an end of life position. Resident #99 was in the B side of room 410. He was on an air mattress with bilateral side rails in up position and was on oxygen delivered through a nasal cannula. Residents #31, #83 and #47 were observed to roam in and out of room 410 during the dates indicated. On 3/21/13 at 10:00 a.m., a white, mesh banner with a red stop sign was placed onto the door frame of room 410. Residents #31 and #47</p>	F000282	<p>F282 – Services by Qualified Persons/Per Care Plan</p> <p>It is the practice of this provider that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>Resident #99</i> –has been discharged from the facility <i>Resident #31</i> – Family and physician have been updated regarding this resident's current status. His care plan and care sheet have been updated to reflect his current status and needs. This resident experienced no negative outcome as a result of this finding <i>Resident #83</i> – Family and physician have been updated regarding this resident's current status. His care plan and care sheet have been updated to reflect his current status and needs. This resident experienced no negative outcome as a result of this finding <i>Resident #47</i> – Family and physician have been updated</p>	04/24/2013			

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	<p>were observed to enter room 410 of Resident #99 after the Velcro meshed banner was placed.</p> <p>On 3/21/13 at 11:00 a.m., an interview with the MDS was conducted alongside of a record review of Resident #99's care plans. MDS nurse indicated "...no, (Resident #99's name) does not anything in his care plan that protects him for others wandering into the room..." The Care Plans for Resident #99 were reviewed which indicated "...at risk for falls due to impaired mobility, incontinence, hx of fall prior to admission, receives a daily antidepressant, hx of c/o pain, poor safety awareness, impaired cognition; dx. HTN, dementia, copd, a fib.... and that Resident #99 was an "...extensive assist..." with activity of daily living and ambulation. Resident #99 was not observed to move from his supine position from the observations dates noted above.</p> <p>2) On 3/21/13 at 2:30 p.m., an observation was made of Resident #31 self propelling her wheelchair into Resident #99's room. A mesh banner with a red stop-sign located in the middle was Velcroed to either side of the residents room door frame. This banner was being used to discourage wandering of other residents into the</p>		<p>regarding this resident's current status. His care plan and care sheet have been updated to reflect his current status and needs. This resident experienced no negative outcome as a result of this finding</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>All residents have the potential to be affected by this finding. A facility audit will be conducted by the Care Plan Team. This audit will include review of all resident care plans related to wandering type behaviors. These care plans will be reviewed and updated to reflect each resident's current status as it relates to wandering behaviors by the Care Plan Team. Interventions will be reviewed and updated by the Care Plan Team to reflect monitoring wandering residents, redirecting wandering residents as necessary, providing supervision to wandering residents and involving wandering residents in facility activities of their choice. C.N.A. Assignment Sheets will be updated by the Care Plan Team. Any changes/updates to care plan interventions will be promptly communicated to all direct care staff. A mandatory nursing in-service will be conducted on or before 4/23/13 by the DNS/designee.</p>				

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	<p>room. Resident #31 pulled the Velcro away from the left side of the door frame, dropped the Velcro sign to the ground and proceeded to self propel into the room. Resident #99 was observed lying in the B side bed. The wheelchair Resident #31 was in became lodged between the bed and dresser on the A side of the room. Resident #31 became stuck and couldn't maneuver the wheelchair either forward or backward.</p> <p>On 3/21/13 at 2:40 p.m., an observation was made of Employee #4 to enter the room and redirect Resident #31 into the hallway.</p> <p>On 3/22/13 at 10:45 a.m., interview with Employee #18 indicated Resident #31 was not to be entering other resident rooms, however, this resident was known to wander in and out of residents rooms.</p> <p>On 3/22/13 at 11:00 a.m., a record review was conducted of Resident 31's Care Plan which indicated that Resident #31 was care planned for wandering into others rooms and that Resident #31 was to monitored for wandering.</p> <p>On 3/25/13 at 11:30 a.m., review was conducted of Resident #31's</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: A mandatory nursing in-service will be conducted on or before 4/23/13 by the DNS/designee. This in-service will include review of the facility policy related to care and supervision of residents with wandering type behaviors. All nursing staff will be re-educated on the process of reviewing, updating and following all resident care plans specifically related to residents with wandering type behaviors. Interventions such as monitoring wandering residents, redirecting wandering residents as necessary, providing supervision to wandering residents and involving wandering residents in facility activities of their choice will be discussed and reviewed. DNS/designee will conduct rounds on all shifts daily until compliance is achieved to ensure interventions for wanderers are implemented per Care Plan and C.N.A. Assignment Sheet.</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: Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completion of the</p>		

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	<p>MDS(minimum data system) dated 7/30/12 and 1/25/13. The following were indicated: "...7/30/12. C1000. Cognitive Skills for Daily Decision Making. Made decisions regarding tasks of daily life. [scale from 0-3, with 0 indicating awareness and 3 sever impairment]. 2. Moderately impaired- decision making poor; cues/ supervision required..." "...1/25/13. C1000. Cognitive Skills for Daily Decision Making. Made decisions regarding tasks of daily life. [Scale noted previously]. 3. Severely impaired- never/rarely made decision. C1300. Delirium. Signs and Symptoms of Delirium. A. Inattention- Did the Resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)? 1.= Behavior consistently present, does not fluctuate. Section D. Mood. D0100. E0900. Wandering- Presence and Frequency. Has the resident wandered? 0. Behavior not exhibited...."</p> <p>3) On 3/21/13 at 3:30 p.m., an observation was made of Resident #83. An alarm sounding was emitted from room 410. Resident #83 was observed to be walking around room 410 and to be on the B side of the room and touching the bed, side rails</p>		<p>CQI Audit tool titled, "Care Plan Updating" weekly x 3 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance date = 4/24/13.</p>				

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	<p>and belongings of the roommate located in bed B (Resident #99). Resident #99 was observed to be lying in the B side bed.</p> <p>On 3/21/13 at 3:40 p.m., Employee #23 was observed to enter room 410, closed the door and re-opened the door and was then observed to push Resident #83 down the hallway, who was now seated in a wheelchair.</p> <p>On 3/21/13 at 3:50 p.m., Employee #23 was observed to be assisting Resident #83 to eat soda crackers. Interview with Employee #23 at this time indicated Resident #83 had been moved on this date to room 216.</p> <p>On 3/21/13 at 3:52 p.m., an observation was made of Resident #83 self propelling down the hallway away from the nurses station of the 400 hall.</p> <p>On 3/21/13 at 3:55 p.m., review of the behavioral care plan for Resident #83 indicated "...Intervention #1 Staff to redirect. #2 Offer diversional activity. #3 Monitor whereabouts... #5 Exit seeking, intrusive behaviors...." Review of the most recent Physicians order form, dated 3/19/13, indicated there was no order noted for a transfer of rooms. The last room</p>			

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	<p>noted was 404.</p> <p>On 3/21/13 at 4:00 p.m., interview with Employee #23 indicated that Resident #83 was transferred to room 410 from room 404 but was unsure why.</p> <p>On 3/21/13 at 4:05 p.m., interview with Employee #14 indicated Resident #83 had originally be roomed on the Cottage Unit, the secured, locked Alzheimer's unit and that because of the resident's inability to participate in the program on the Cottage Unit in relation to outcomes, Resident #83 was relocated outside of the Cottage Unit. Employee #14 further indicated "... here [outside of the Cottage locked unit] ...will get more therapy versus back in the Cottage... they're kinda hard to read [in reference to therapy notes]...indicated: ST [speech therapy] 3/15/13 5 x [times] week for 4 weeks- cognition staging; 3/15/13 PT [physical therapy] 5 x week for 12 weeks; 3/15/13 OT [occupational therapy] 5 x week for 12 weeks...."</p> <p>On 3/22/13 at 2:00 p.m., an observation was made of Resident #83 self propelling his wheelchair through the doorway of room 410. The Velcro mesh banner was draped</p>				

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	<p>downward and lying to the floor. Resident #83 wheeled into the room.</p> <p>On 3/22/13 at 2:30 p.m., interview with the DNS (Director of Nursing Services) indicated Resident #83 was not to be in the room and wanders into rooms on occasion.</p> <p>On 3/22/13 at 3:00 p.m., an observation was made of Resident #83 to be lying sideways in the 410 room on the A side of the bed; both 1/3 side rails were pulled to the up position with the side rail closest to the doorway being half up and half down and Resident #83's wheelchair was pulled close to the bed. There was an alarm attached to the wheelchair and it was not alarming.</p> <p>4.) On 3/22/13 at 10:00 a.m., an observation was made of Resident #47 in a wheelchair and was self propelling the wheelchair into Room 410 of Resident #99. Resident #47 was not a resident of this room.</p> <p>On 3/25/13 at 10:30 a.m., review of the care plans for Resident #47 indicated they did not include 'wandering' but included the following: "...Problem. Problem start date: 10/4/2012. Behavior. (2). Resident exhibiting Exit seeking behaviors:</p>						

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	<p>Making attempts to exit front doors without appropriate supervision. Goal. Long Term Goal Target Date: 4/8/2013. Goal: Resident will not make attempts to exit front doors, daily through next review... Approach Start Date: 10/3/12. Resident exhibiting Exit seeking behaviors. Making attempts to exit front doors without appropriate supervision....Interventions:...Wander guard in place....Remove resident immediately... call family to talk with resident... psych consult as needed... Problem. Problem Start Date: 1/25/13. Resident at risk for falling R/T [related to] impaired mobility r/t severe osteoarthritis to legs, back, and hips, unsteady balance/gait, receives daily antidepressant medication, poor safety awareness. Resident at times will transfer self unassisted. Hx [history] of left hip fracture. Goal: Resident will be free from injury. Approach Start Date: 11/23/12....remind resident not to ambulate/ transfer without assistance...."</p> <p>On 3/25/13 at 11:00 a.m., review of Resident #47's MDS dated 1/1/2013 indicated "... Section D. Mood. E0900. Wandering - Presence and Frequency. Has the Resident wandered? 0. Behaviors not</p>						

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	<p>exhibited...."</p> <p>On 3/25/13 at 11:30 a.m., an interview with the DNS indicated Resident #47 should not be wandering into other rooms and should be supervised.</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1) Based on observations, record reviews and interviews, the facility failed to ensure that Resident #99 did not fall out of his bed. This affected 1 of 1 sampled for falls. (Resident #99)</p> <p>2) Based on observation, interview and record review, the facility failed to provide appropriate supervision to prevent the wandering of 2 residents. This affected 2 of 3 residents sampled for wandering. (Resident #47 and #83)</p> <p>Findings included:</p> <p>1) On 3/22/13 at 9:15 a.m., an observation was made of a female voice loudly requesting, "...HELP, HELP... I need some HELP..." Upon observation in response to the request for help, CNA #19 was kneeling at the left side of the resident bedframe at the head of the bed. CNA #19 stated, "...I just came in here and he was like this...." An observation was made of Resident #99, who was half in and half out of</p>	F000323	<p>F323 – Free of Accident Hazards/Supervision It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: <i>Resident #99</i> – has been discharged from the facility <i>Resident #47</i> - Family and physician have been updated regarding this resident's current status. Her care plan and care sheet have been updated to reflect her current status and needs. This resident experienced no negative outcome as a result of this finding. Resident is being monitored to curtail intrusive wandering. <i>Resident #83</i> - Family and physician have been updated regarding this resident's current status. His care plan and care sheet have been updated to reflect his current status and</p>	04/24/2013			

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	<p>his bed. Side rails were up, full position and level of bed was not in lowest level observed by the bed being approximately at waist level in height. The side rails were 1/3 in length and were placed in the center portion of the bed. There was a bed alarm noted to be connected to the trunk level of the bed with the alarm itself located beneath the bed. The alarm was not alarming at this time. There was not a fall mat on either side of the bed. There was not a visible call light to activate. Resident #99 was situated between the side rail on the left side of the bed and the floor. The top of his head was on the floor, as was his left shoulder and left arm. His right shoulder was noted to be at the frame of the bed. His waist was situated between the side rail and the bed mattress. The lower trunk and legs were positioned on the bed and twisted towards the left side. Other staff were summoned. An observation was made of the resident's left forearm/ bicep area, which was noted to be wrapped in gauze and had bright red blood noted.</p> <p>On 3/22/13 at 9:35 a.m., the DNS (Director of Nursing Services) indicated the resident had two skin tears, one on each upper arm. The</p>		<p>needs. This resident experienced no negative outcome as a result of this finding. Resident is being monitored to curtail intrusive wandering.</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>Any resident identified as being at risk for falls, need for use of side rails, or exhibits wandering type behaviors has the potential to be affected by this finding. A side rail assessment has been completed for all residents. A facility audit will be completed by the Nurse Management Team to review all resident fall, wandering, and use of side rails, care plans. The prevention interventions on each resident's fall, wandering, and use of side rails care plan will be reviewed and compared to the Nurse Aide Assignment Sheet to ensure all interventions are in place and being utilized per the individual plan of care. In addition, environmental inspections of resident rooms and equipment will be completed through the facility Customer Care Program no less than five times per week. This audit will ensure all fall, wandering prevention, and side rails interventions are in place and properly being utilized per the individual plan of care. A nursing in-service will be held on or</p>				

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	<p>family and the Medical Doctor(MD) had been notified and CNA #19 was sitting with the resident until the facility had a reply back from the MD.</p> <p>On 3/22/13 at 9:40 a.m., review of the Minimum Data System (MDS) which indicated in Section C for Cognition functioning, the BIMS (Brief Interview for Mental Status) was conducted upon initial assessment on 2/15/13 and a score of 5 out of a possible 15 was indicated. Section F for functional status indicated Resident #99 was extensive dependence for activities of daily living (ADL) and for transfers, eating and toileting and personal hygiene. Review of the code status for Resident #99 indicated a Full Code status was intact.</p> <p>On 3/22/13 at 9:41 a.m., an interview with the Assistant Director of Nursing (ADON) indicated that the, "...electrical charting is not kept as up to date as the paper charts on at the nurses stations..." It was reviewed on the electrical chart that Resident #99 was a "...Full Code..." status. Upon review of the 'paper' charting, it was observed that Resident #99 had been labeled a "...No-Code Status..." An 'Out-of-Hospital DNR declaration' form was completed on 3/18/13 and declared Resident #99 as a Do not</p>		<p>before 4/23/13. The DNS/designee is responsible for conducting this in-service. This in-service will review the facility policy titled, "Fall Management Program," "Side Rail Assessments," and include Residents with Wandering Behaviors. This in-service will also include review of the care plan process and importance of adherence to established care plans and safe practices in regards to resident safety, fall prevention, side rail use, and wandering behaviors.</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: A nursing in-service will be held on or before 4/23/13. The DNS/designee is responsible for conducting this in-service. This in-service will review the facility policy titled, "Fall Management Program," "Side Rail Assessment Procedure," and include Residents with Wandering Behaviors. This in-service will also include review of the care plan process and importance of adherence to established care plans and safe practices in regards to resident safety, fall, side rail use, and wandering prevention. In addition, environmental inspections of resident rooms and equipment will be completed through the facility Customer Care Program</p>				

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	<p>code status in the event of an end of life situation. The ADON indicated "... (resident #99's name) is not a Full code... that is not correct..."</p> <p>On 3/22/13 at 9:42 a.m., an observation was made of the Maintenance Manager removing Resident #99's side rails.</p> <p>On 3/22/13 at 9:42 a.m., a review was conducted alongside of the ADON of Resident #99's clinical medical record (CMR) which indicated in the care plan that Resident #99 was to use the call light for requesting help. Upon further review it was noted the Resident #99 was an extensive assistance resident. Interview with the ADON at this time indicated "...when [resident #99's name] was first admitted, a call light could be used...the facility puts this on everyone's care plan regardless of the ability to use the call light..."</p> <p>Review of the fall assessment indicated Resident #99 did not have a history of falls, was currently using a chemical narcotic for pain and was cognitively impaired due to aphasic issues and was labeled "...confused...."</p> <p>On 3/22/13 at 9:43 a.m., a review was requested of a side rail assessment</p>		<p>no less than five times per week. This audit will ensure all safety, fall, side rail use, and wandering prevention interventions are in place and properly being utilized per the individual plan of care. Any change in resident safety needs will be identified during daily clinical meetings. Changes will be communicated by the Nurse Management Team/designee to direct care staff promptly through updates to care plans and Nurse Aide Assignment Sheets. DNS/designee will conduct daily rounds on all shifts until compliance achieved to ensure interventions for wanderers are implemented per Care Plan and C.N.A. Assignment Sheet.</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 with these corrective actions, the DNS/designee will complete the CQI Audit Tools titled, "Fall Management," "Care Plan Updating," and "Side Rails" weekly for 3 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date: 4/24/13.</p>				

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	<p>for Resident #99. The ADON indicated at this time "...there is not one..."</p> <p>On 3/22/13 at 9:44 a.m., review of the side rail assessment provided by the MDS nurse indicated "...Side Rail Assessment... Side rail(s) are not to be used for resident (if checked do not continue, this assessment is complete)..." This item was checked. Further review indicated "...Type of side rail(s) needed: 2- positioning rails...Explain reason for choice of side rail(s) including both sides, left or right..." (left blank); "...The use of side rails is safe due to the following (check all that apply)..." (left blank). The choices that were available for the item side rail(s) is safe due to the following were noted: "...Resident is capable of using call light to request for transfers, Resident does not attempt to get out of bed voluntarily, Resident does not attempt to climb over, around or through side rails..." All choices were left blank.</p> <p>On 3/22/13 at 9:45 a.m., an interview and electronic chart review was conducted alongside of the ADON and MDS nurse. Review of the MDS indicated "... side rails for interventions in the care plans are not placed under fall risks, they are under</p>			

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	<p>skin integrity problems... the side rails themselves help the resident to reposition themselves..." A care plan for skin integrity was reviewed which did not indicate side rails to be an 'approach' for an intervention, nor did it indicate an 'air mattress with bolsters.' There was not a need for side rails identified in the care plans.</p> <p>On 3/22/13 at 11:00 a.m., a care plan for falls for Resident #99 was reviewed alongside of the MDS nurse which indicated "...Problem Start Date: 2/8/2013. Resident is at risk for falls due to impaired mobility, incontinence, hx [history] of fall prior to admission, receives daily antidepressant, hx of c/o [complained of] pain; dx [diagnosis], HTN [hypertension], dementia, copd [chronic obstructive pulmonary disease], a fib [atrial fibrillation]. Goal Target Date: 5/26...Approach:...Non skid foot wear...2/8/13; Environmental changes as needed...2/8/13; Call light in reach...2/8/13; Bed Alarm...2/9/13; ...Fall mat at bedside... 3/22/13; Bolsters to air mattress...3/22/13; Bed in lowest position...3/22/13...."</p> <p>On 3/22/13 at 11:02 a.m., an interview with LPN #20 indicated she had completed the initial temporary care plan for Resident #99 and that a</p>			

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	<p>Fall risk had been indicated related to risk factors identified on the fall risk assessment tool. Review of the fall risk care plan at this time indicated "...Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait, encourage resident to use call light... provide assistance for transfers and bed mobility..." this was dated as completed on 3/19/13 at 5:03 p.m.</p> <p>On 3/22/13 at 11:05 a.m., review of the "...Side Rail Assessment Procedure..." indicated "...Policy: It is policy of (name of corporate ownership) to prohibit the use of side rail(s) for the purpose of discipline or convenience... [Procedure for] completing the side rail assessment.: 1. A side rail assessment will be completed on all newly admitted/re-admitted residents to determine the need for any type of side rail(s) and/or positioning device(s)...2...If the resident does not need side rails, check the section, sign and date the form...."</p> <p>On 3/22/13 at 11:06 a.m., review of a Physicians Telephone Order, dated 3/22/13 at 9:45 a.m., indicated "...increase Roxanol to 10 mg/0.05ml q [every] 1 hr [hour] for s/s [signs and symptoms] of pain PRN [as</p>			

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	<p>needed]...bed to lowest position unless receiving care...Coverlet to bed for prevention of falls...fall mat to floor...d/c[discontinue] side rails...."</p> <p>2A) On 3/21/13 at 2:30 p.m., an observation was made of Resident #47 self propelling her wheelchair into Resident #99's room. A mesh banner with a red stop-sign on it was velcroed to either side of the residents room door frame. This banner was to discourage wandering of other residents into the room. Resident #47 pulled the velcro away from the left side of the door frame, dropped the velcro sign to the ground and proceeded to self propel into the room.</p> <p>On 3/22/13 at 10:45 a.m., interview with Employee #18 indicated Resident #47 was not to be entering other resident room, however, this resident was known to wander in and out of residents rooms.</p> <p>On 3/25/13 at 11:00 a.m., a review was conducted of the care plan for Resident #47 which indicated nothing addressing wandering into other residents rooms. Resident #47's care plan only indicated "...Problem: Start Date: 10/4/2012. Behavior: (2) Resident exhibiting Exit seeking</p>			

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	<p>behaviors: Making attempts to exit front doors without appropriate supervision....Goal: Resident will not make attempts to exit front doors, daily through next review...."</p> <p>2B) On 3/15/13 at 11:00 p.m., a review was conducted of the care plan for Resident #83 which indicated nothing addressing wandering into other residents rooms. Resident #83's care plan only indicated "...Problem Start Date: 11/17/2012. Resident is at risk for elopement due to: Resident resides on secure memory unit Dx: dementia. Goal: Resident will not leave the facility unattended..."</p> <p>On 3/22/13 at 2:00 p.m., an observation was made of Resident #83 to be self propelling his wheelchair through the doorway of room 410. The velcro mesh banner was drapped downward and lying to the floor. Resident #83 wheeled into the room.</p> <p>On 3/22/13 at 2:30 p.m., an interview the DNS indicated Resident #83 was not to be in the room and wanders into rooms on occasion.</p> <p>3.1-45(a)(2)</p>				

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F000329 SS=E	<p>483.25(I) 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>1) Based on interview and record review the facility failed to appropriately monitor the blood pressure and/or pulse per physician order before giving a cardiac medicine for 4 of 4 residents in a sample of 10 who fit the criteria for unnecessary medications. (Resident's #34, #22, #23, and #36)</p> <p>2) Based on record review and interview the facility failed to accurately monitor blood glucose as</p>	F000329	<p>F329 – Drug Regimen Is Free From Unnecessary Drugs</p> <p>It is the intent of this provider that each resident's drug regimen be free from unnecessary drugs.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>Resident #34</i> –physician and family have been notified of resident's pulse and blood pressure results. Vital signs are being obtained and recorded as ordered. This resident</p>	04/24/2013			

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	<p>ordered by the physician on 2 residents (Residents #23 and # 24) sampled out of 21 residents with blood glucose monitoring in the facility.</p> <p>Findings include:</p> <p>1A) On 3/20/13 at 2:00 P.M., review of the clinical record for Resident #34 indicated diagnoses including but not limited to "...atrial flutter [heart arrhythmia], cva [cardiovascular accident], hypertension [high blood pressure], hyperlipidemia, acute hemorrhagic stroke, parosymal [sic] atrial fibrillation [heart arrhythmia],...."</p> <p>Physician orders written 5/4/09 indicated "Diltiazem [cardiac medicine for heart arrhythmia] 60 mg [milligram] tab. Take 1 tab by mouth/per g tube [gastric tube] 4 times daily at 8 A.M., 1 P.M., 5 P.M., and 9 P.M....*Hold for systolic blood pressure < [less than] 90*..." and "...Metoprolol Tar [cardiac medicine for hypertension] 50 mg tab. Take 1 tab by mouth/per g tube daily at 1 P.M....*Hold for systolic blood pressure <100*...". A Physician order written on 8/31/09 indicated "...blood pressure daily (document in computer)...."</p>		<p>experienced no negative outcome related to this finding. Resident is receiving medication per physician order.</p> <p><i>Resident #22</i> – physician and family have been notified of resident's pulse and blood pressure results. Vital signs are being obtained and recorded as ordered. This resident experienced no negative outcome related to this finding. Resident is receiving medication per physician order.</p> <p><i>Resident #23</i> – physician and family have been notified of resident's pulse and blood pressure results as well as past and present blood glucose monitoring results. Vital signs and blood glucose checks are being obtained and recorded as ordered. This resident experienced no negative outcome related to these findings. Resident is receiving medication per physician order.</p> <p><i>Resident #36</i> - physician and family have been notified of resident's pulse and blood pressure results. Vital signs are being obtained and recorded as ordered. This resident experienced no negative outcome related to this finding. Resident is receiving medication per physician order.</p> <p><i>Resident #24</i> - physician and family have been notified of resident's past and present blood glucose monitoring results. Blood glucose checks are being</p>				

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	<p>On 3/20/13 at 2:31 P.M., review of Resident #34's hypertension care plan indicated "...Problem: Ineffective tissue perfusion related to: htn [hypertension], atrial flutter...Approach:...administer meds as ordered...monitor VS [Vital Signs]...."</p> <p>On 3/20/13 at 2:35 P.M., review of Resident #34's vital signs documented in the facility computer program indicated the following dates and times for March 2013 were missing a documented blood pressure to correspond with the administration of the ordered Diltiazem and/or Metoprolol: 3/20: 8 A.M., 1 P.M., 5 P.M., and 9 P.M. 3/19: 5 P.M. and 9 P.M. 3/18: 8 A.M., 1 P.M., 5 P.M., and 9 P.M. 3/17: 5 P.M. and 9 P.M. 3/16: 1 P.M., 5 P.M., and 9 P.M. 3/15: 5 P.M. and 9 P.M. 3/14: 8 A.M., 1 P.M., 5 P.M., and 9 P.M. 3/13: 8 A.M. and 9 P.M. 3/12: 8 A.M., 1 P.M., 5 P.M., and 9 P.M. 3/11: 8 A.M., 1 P.M., 5 P.M., and 9 P.M. 3/10: 8 A.M., 1 P.M., 5 P.M., and 9 P.M.</p>		<p>obtained and recorded as ordered. This resident experienced no negative outcome related to these findings. Resident is receiving medication per physician order.</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: Any resident with orders for blood glucose monitoring and/or orders to obtain and record vital signs prior to medication administration is at risk to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will review all residents with physician's orders for blood glucose monitoring and/or obtaining and recording vital signs prior to medication administration. The Nurse Management Team will then review clinical records to ensure that vital signs are obtained as ordered prior to medication administration and that blood glucose results are obtained, documented, and administered per physician's order. The Nurse Management Team will be responsible for daily review of MARs and Blood Glucose Monitoring Records to ensure vital signs have been obtained and recorded prior to medication administration, blood glucose results have been obtained and documented as ordered and</p>				

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	<p>3/9: 8 A.M., 1 P.M., 5 P.M., and 9 P.M. 3/8: 5 P.M. and 9 P.M. 3/7: 5 P.M. and 9 P.M. 3/6: 1 P.M., 5 P.M. and 9 P.M. 3/5: 1 P.M., 5 P.M., and 9 P.M. 3/4: 1 P.M., 5 P.M., and 9 P.M. 3/3: 1 P.M. 3/2: 1 P.M. and 9 P.M. 3/1: 1 P.M., 5 P.M. and 9 P.M.</p> <p>1B) On 3/21/13 at 9:51 A.M., review of the clinical record for Resident #22 indicated diagnoses including but not limited to "...hypertension, myocardial infarction [heart attack], chronic atrial fibrillation, hyperlipidemia, h/o [history of] AICD [automatic implantable cardioverter defibrillator] placement [pacemaker], ischemic cardiomyopathy [heart muscle weakness], CABG [coronary artery bypass graft] x [times] 4 vessels, CAD [coronary artery disease]...."</p> <p>Physician order dated 12/10/09 indicated "...Amiodarone [cardiac medication for heart arrhythmia] 200 mg tab. Take 1 capsule by mouth once daily (Notify MD if Apical Pulse < [less than] 60 or > [greater than] 120) at 8 A.M...."</p> <p>Review of Resident #22's care plan's</p>		<p>physicians have been notified of results when appropriate. A mandatory nursing in-service will be conducted by the DNS/designee on or before 4/23/13. This in-service will include review of the facility policy titled, Medication Administration Procedure including obtaining and recording vital signs prior to specific medication administration and Blood Glucose Monitoring with physician notification when appropriate.</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: A mandatory nursing in-service will be conducted by the DNS/designee on or before 4/23/13. This in-service will include review of the facility policy titled, "Medication Administration Procedure" including obtaining and recording vital signs prior to specific medication administration and "Blood Glucose Monitoring" with physician notification when appropriate. The Nurse Management Team will be responsible for daily review of MARs and Blood Glucose Monitoring Records to ensure vital signs have been obtained and recorded prior to medication administration, blood glucose results have been obtained and documented as ordered and physicians have been notified of results when appropriate.</p>				

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	<p>indicated "...Problem: Ineffective tissue perfusion related to dx: [diagnosis] htn, hx [history] of MI [Myocardial infarction], afib [atrial fibrillation], CAD, hyperlipidemia, hx of CABG, ischemic cardiomyopathy...Approach:...administer meds as ordered...VS as ordered and prn [as needed]...."</p> <p>On 3/21/13 at 10:26 A.M., review of the current MAR (Medication Administration Record) for March 2013 and of the vital signs documented in the facility computer program for Resident #22 indicated the following dates did not have an Apical Pulse documented to correspond with the administration of the ordered Amiodarone: 3/20, 3/11, 3/10, 3/3/13.</p> <p>On 3/21/13 at 10:40 A.M., review of the past MAR's for February and January and of the vital signs documented in the facility computer program for Resident #22 indicated the following dates did not have an Apical Pulse documented to correspond with the administration of the ordered Amiodarone: 2/22, 2/21, 2/18, 2/10, 2/9, 2/8, 2/3, 1/30, 1/27, 1/26, 1/18, 1/17, 1/5, and 1/4/13.</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: To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit tools titled, "MAR/TAR Review" and "Blood Glucose Monitoring" weekly for 4 weeks, then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance date = 4/24/13.</p>		

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	<p>1C) On 3/21/13 at 2:20 P.M., review of the clinical record for Resident #23 indicated diagnoses including but not limited to "...hyperlipidemia, htn...."</p> <p>Review of the Physician order summary indicated the following: Physician order dated 12/3/12 indicated "...Vital Signs once daily...". Physician orders dated 12/4/12 indicated "...Diovan [cardiac medication for blood pressure] 80 mg tab. Take 1 tab by mouth once daily *Hold for SBP [systolic blood pressure] < 110*...." and "...Furosemide [diuretic] 20 mg tab. Take 1 tablet by mouth daily *Hold if systolic blood pressure , <(less than)100*...."</p> <p>On 3/21/13 at 2:55 P.M., review of the MAR for March and February 2013 and of the vital signs documented in the facility computer program for Resident #23 indicated the following dates did not have a blood pressure documented to correspond with the administration of the ordered Diovan and Furosemide: 3/20, 3/19, 3/18, 3/17, 3/16, 3/15, 3/13, 3/12, 3/11, 3/9, 3/8, 3/7, 3/6, 3/5, 3/4, 3/3, 3/2, 3/1, 2/28, 2/27, 2/26, 2/25, 2/24, 2/23, 2/22, 2/21, 2/20, 2/19, 2/18, 2/17, 2/16, 2/15, 2/14, 2/13, 2/12, 2/10, 2/9, 2/8, 2/7,</p>			

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	<p>2/6, 2/5, 2/4, 2/3, 2/2, and 2/1/13.</p> <p>On 3/21/13 at 3:09 P.M., interview with the Assistant Director of Nursing (RN #16) indicated the missing vital signs should be documented in the computer or in the nurses notes. Upon review at this time, there was no documentation of any vital signs in the nurses notes for the above mentioned dates.</p> <p>1D) On 3/22/13 at 10:40 A.M., review of the clinical record for Resident #36 indicated diagnoses including but not limited to "...htn...."</p> <p>Physician order dated 8/23/11 indicated "...Lisinopril 10 mg tab. Take 1 tablet by mouth once daily *Hold if systolic blood pressure < 90 or diastolic blood pressure <60*...."</p> <p>On 3/22/13 at 11:00 A.M., review of the MAR's for March and February 2013 and of the vital signs documented in the facility computer program indicated the following dates did not have a blood pressure documented to correspond with the administration of the ordered Lisinopril: 3/21, 3/19, 3/18, 3/17, 3/16, 3/15, 3/14, 3/13, 3/12, 3/11, 3/8, 3/7, 3/6, 3/5, 3/4, 3/3, 3/2, 3/1, 2/27 and</p>			

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	<p>2/23/13.</p> <p>On 3/22/13 at 12:00 P.M., interview with the Director of Nursing (RN #9) indicated the missing blood pressures and pulses for all above mentioned residents should have been obtained and documented in the computer per Physician order.</p> <p>On 3/22/13 at 2:08 P.M., review of the Pharmacy "Medication Administration Guidelines" received from the DON (RN #9) which was indicated to be used as a medication administration guideline for the facility indicated "...To ensure that: the right resident gets the right medication at the right time, in the right dosage, via the right route...to comply with the State and Federal Guidelines for administration of medications...Pulse, blood pressure or other vital signs are to be monitored and charted when applicable and as per the prescribers order...."</p> <p>2A) On 3-20-13, at 2:35 PM, record review for Resident #24 indicated blood glucose monitoring ordered for 15 minutes before breakfast, lunch, and supper, without sliding scale Novolog coverage at 7 AM check. Physician order dated 7-13-2011. Records indicated on the Capillary</p>						

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	<p>Blood Glucose Monitoring Tool located in the front of the Medication Administration Record (MAR) on: February 2, 2013, blood glucose not documented at 11 AM February 3, 2013, blood glucose not documented at 7 AM and 11 AM February 4, 2013, blood glucose not document at 7 AM February 6, 2013, blood glucose checked at 7 AM with 2 units of Novolog given at 7 AM February 7, 2013, blood glucose not documented at 11 AM February 8, 2013, blood glucose not documented at 11 AM February 9, 2013, blood glucose checked at 7 AM with 1 unit of Novolog given at 7 AM February 11, 2013, blood glucose not documented at 11 AM February 12, 2013, blood glucose not documented at 11 AM and 9 PM with one unit of Novolog given at 9 PM February 13, 2013, blood glucose not documented at 11 AM February 14, 2013, blood glucose checked at 7 AM with one unit of Novolog given at 7 AM February 15, 2013, blood glucose checked at 7 AM with 2 units of Novolog given at 7 AM February 16, 2013, blood glucose checked at 7 AM with 2 units of Novolog given at 7 AM and not</p>			

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	<p>documented at 11 AM February 17, 2013, blood glucose checked 7 AM with one unit of Novolog given at 7 AM February 18, 2013, blood glucose not documented at 11 AM February 19, 2013, blood glucose checked at 9 AM, and not documented at 11 AM February 21, 2013, blood glucose not documented at 11 AM February 22, 2013, blood glucose checked at 7 AM with one unit of Novolog given at 7 AM and not documented at 11 AM February 23, 2013, blood glucose checked at 7 AM and 3 units of Novolog given at 7 AM February 24, 2013, blood glucose not documented at 11 AM February 25, 2013, blood glucose not documented at 11 AM and checked at 9 PM with one unit of Novolog given at 9 PM February 26, 2013, blood glucose not documented at 11 AM and checked at 9 PM with one unit of Novolog given at 9 PM February 28, 2013, blood glucose not documented at 11 AM March 2, 2013, blood glucose checked at 7 AM with one unit of Novolog given at 7 AM and not documented at 11 AM March 3 and 4, 2013, blood glucose</p>						

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	<p>not documented at 11 AM March 5, 2013, blood glucose checked at 7 AM with 4 units of Novolog given at 7 AM, not documented at 11 AM March 6, 7, 8, 2013, blood glucose not documented at 11 AM March 9, 2013, blood glucose checked at 7 AM with one unit of Novolog given at 7 AM March 10, 2013, blood glucose checked at 7 AM with one unit of Novolog given at 7 AM March 11, 2013, blood glucose checked at 7 AM with 2 units of Novolog given at 7 AM. no documentation at 11 AM March 12, 2013, blood glucose was checked at 7 AM and 4 units of Novolog given, not documented at 11 AM and 4 PM March 13, 2013, blood glucose checked at 7 AM with 3 units of Novolog given at 7 AM March 14, 2013, blood glucose checked at 7 AM with 3 units of Novolog given at 7 AM, not documented at 11 AM March 15, 16, and 17, 2013, blood glucose not documented at 11 AM March 19, 2013, blood glucose checked at 7 AM with 2 units of Novolog given at 7 AM March 20, 2013, blood glucose checked at 7 AM with 2 units of</p>				

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	<p>Novolog given at 7 AM March 21, 2013, blood glucose checked at 7 AM with 2 units of Novolog given at 7 AM</p> <p>On 3-20-2013, at 2:40 PM, review of the nurses notes the month of February and March did not indicate that the resident was gone from the facility or any reason as to why the glucose checks should not have been completed. The nurses notes did not indicate that the Novolog given at 7 AM on multiple dates without order were reported to the physician, resident, or responsible party, nor was the resident monitored for medication error.</p> <p>On 3-20-2013 at 2:44 PM, review of the care plan dated 6-30-2011, Resident # 24 related to problem indicated: Resident is at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of Diabetes Mellitus. Plan includes but is not limited to "giving medications as ordered" and "monitor blood sugars as ordered."</p> <p>On 3-20-2013 at 2:47 PM, diagnosis list reviewed for Resident #24 located on the MAR, dated 3-1-2013, indicated that DM2 (Diabetes Mellitus)</p>			

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	<p>was a diagnosis for this resident.</p> <p>2B) On 3-21-2013 at 10:00 AM, record review for Resident # 23 indicated that a Physician order, dated 12-30-2012, for blood glucose monitoring AC and HS (before breakfast, lunch, dinner and at bedtime) with a sliding scale Novolog subcutaneous injection as indicated. Records indicated on the Capillary Blood Glucose Monitoring Tool located in the front of the MAR on: March 1, 2013, blood glucose not documented at 11 AM and 4 PM March 19, 2013, blood glucose not documented at 9 PM March 21, 2013, blood glucose not documented at 9 PM</p> <p>On 3-21-2013 at 10:03 AM, review of the nurses notes for these dates revealed no indication that resident was not gone from the facility. Nurses notes for these dates did not indicate that the physician, resident, or responsible party was called related to the omissions or that the blood glucose checks should not have occurred.</p> <p>On 3-21-2013 at 10:06 AM, review of the care plan dated 12-13-2011, Resident # 23 related to problem indicated: "Resident is at risk for</p>				

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	<p>adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of Diabetes Mellitus." Plan includes but is not limited to "giving medications as ordered" and "monitor blood sugars as ordered."</p> <p>On 3-21-13 at 10:10 AM, diagnosis list reviewed for Resident #23 located on the MAR, dated 3-1-2013, indicated that DM2 (Diabetes Mellitus) was a diagnosis for this resident.</p> <p>On 3-21-13, at 2 PM, an interview with Employee #24 indicated that the readings for blood glucose checks are recorded on the Capillary Blood Glucose Monitoring Tool located in the front of the Medication Administration Record (MAR).</p> <p>On 3-22-2013 at 2 PM, a copy of the facility policy and procedure regarding medication administration was received from the DON. The policy did not have anything specific to blood glucose assessment, administration or documentation. Further interview with DON indicated there was nothing else available related to blood glucose monitoring.</p> <p>On 3-25-2013 at 11:07 AM, interview with Employee #2 indicated that all</p>			

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	<p>blood glucose readings are recorded in the front of the MAR on the Capillary Blood Glucose Monitoring Tool.</p> <p>3.1-48(a)(3) 3.1-48(a)(6)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was distributed or served under sanitary conditions in regard to one employee not wearing a beard protector while in the kitchen and 3 employees serving food while not wearing a hair restraint. This deficiency had the potential to affect 73 of 73 residents who receive meals from the facility kitchen.</p> <p>Findings include:</p> <p>1) On 3/18/13 at 12:05 P.M., Dietary Aide #8 was observed to have facial hair with no beard protector in place while in the facility kitchen.</p> <p>On 3/19/13 at 11:10 A.M. and 12:45 P.M., Dietary Aide #8 was observed to have facial hair with no beard protector in place while in the facility kitchen.</p> <p>On 3/20/13 at 10:25 A.M., Dietary Aide #8 was observed to have facial</p>	F000371	<p>F371 – Food Procure, Store/Prepare/Serve – Sanitary It is the practice of this provider to store, prepare, distribute and serve food in a sanitary manner. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility meals are being distributed and served to all residents using sanitary conditions. None of the residents were negatively affected by this finding. 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: All residents being served during meal service have the potential to be affected by this practice. Staff responsible for dishing up food during meal service is using hair nets and facial hair coverings per facility policy and are utilizing proper food handling techniques during meal service. What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	04/24/2013	

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	<p>hair with no beard protector in place while in the facility kitchen.</p> <p>On 3/21/13 at 9:40 A.M. and 11:50 A.M., Dietary Aide #8 was observed to have facial hair with no beard protector in place while in the facility kitchen.</p> <p>On 3/22/13 at 10:07 A.M., an interview with Employee #7 (Dietary Manager) indicated it was her expectation for kitchen staff to be either clean shaven or to wear a beard protector while in the kitchen, that she had just noticed Dietary Aide #8's facial hair yesterday and had told him to either be clean shaven or wear a beard protector next time he was at work.</p> <p>2) On 3/18/13 at 11:20 A.M., RN #12 was observed on the 200 hall locked dementia unit to be dishing plates of food for residents with no hairnet on.</p> <p>On 3/18/13 at 11:30 A.M., LPN #13 was observed on the 200 hall locked dementia unit to be dishing plates of food for residents with no hairnet on.</p> <p>On 3/18/13 at 11:35 A.M., CNA #2 was observed to dish bowls of fruit for residents on the 200 hall locked dementia unit with no hairnet on.</p>		<p>practice does not recur: An all staff in-service will be conducted on or before 4/23/13 by the ED/DNS/designee. This in-service will include review of the policy titled, "General Food Prep and Handling" as well as "Dietary Personal Hygiene". All staff will be re-educated regarding the importance of storing, preparing, dishing up, distributing and serving food in a sanitary manner by using hair coverings and facial hair protectors when appropriate during meal service as outlined in the facility policy.</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: To ensure ongoing compliance with this corrective action, the ED/DNS/designee will be responsible for completion of the CQI Audit tools titled, "Dining Room Manager Observation Checklist" daily for 30 days and monthly thereafter for at least 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance date = 4/24/13.</p>		

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	<p>On 3/21/13 at 11:15 A.M., LPN #15 was observed on the 200 hall locked dementia unit to be dishing plates of food for residents with no hairnet on.</p> <p>On 3/21/13 at 11:37 A.M., CNA #2 was observed to dish one plate of food for a resident on the 200 hall locked dementia unit with no hairnet on.</p> <p>On 3/22/13 at 10:07 A.M., an interview with Employee #7 (Dietary Manager) indicated it was her expectation for floor staff who dish food would be the same as dietary staff in the kitchen.</p> <p>On 3/22/13 at 12:17 P.M., review of the current Dietary Personal Hygiene policy received from the Administrator at this time indicated "...Employees will maintain good personal hygiene to prevent food contamination...Wear a clean hat and/or other hair restraint. Dietary Employees with facial hair should also wear a beard restraint...."</p> <p>3.1-21(i)(3)</p>				

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F000441 SS=E	<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, interview and record review, the facility failed to</p>	F000441	F441 – Infection Control, Prevent Spread, Linens	04/24/2013			

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	<p>appropriately disinfect the hand held glucometer devices used for measure glucose levels by not washing hands or wearing gloves during the procedure for 4 observed diabetic residents. This deficiency had the potential to affect 21 of 21 residents who receive glucose monitoring. (Residents #28, #2, #54, and #112)</p> <p>Findings include:</p> <p>On 3/21/13 at 3:50 P.M., LPN #10 indicated she was going to check the blood sugar for Resident #28. LPN #10 was observed to retrieve a glucometer machine (used for checking blood sugar), a lancet (used for poking finger to retrieve blood), an alcohol swab, and the glucose test strip from a med cart on 100 hall and proceed to Resident #28's room. After explaining the procedure to the resident, donning clean gloves and obtaining a blood sample for glucose reading, LPN #10 returned to her med cart and indicated she was going to clean the machine as she did after every glucose check. LPN #10 was then observed to use a Super Sani-Cloth Germicidal Disposable Wipe and rub the hand held glucometer machine without washing hands first or wearing gloves for > (greater than) 2 minutes before</p>		<p>It is the practice of this provider to 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>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>Resident #28</i> -experienced no negative outcome as a result of this finding. Staff is using proper technique when disinfecting the glucometer for blood glucose testing</p> <p><i>Resident #2</i> - experienced no negative outcome as a result of this finding. Staff is using proper technique when disinfecting the glucometer for blood glucose testing</p> <p><i>Resident #54</i> - experienced no negative outcome as a result of this finding. Staff is using proper technique when disinfecting the glucometer for blood glucose testing</p> <p><i>Resident #112</i> – No resident #112 could be identified, however, no resident was found to have experienced negative outcome as a result of this finding. Staff is using proper technique when disinfecting the glucometer for blood glucose testing</p> <p>How other residents having the</p>		

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	<p>placing it on a clean napkin to dry completely.</p> <p>On 3/21/13 at 4:07 P.M., LPN #10 indicated she was next going to check the blood sugar for Resident #2. LPN #10 was observed to use the same glucometer machine and the same procedure for checking the blood sugar for Resident #2. LPN #10 was then observed to use a Super Sani-Cloth Germicidal Disposable Wipe and rub the hand held glucometer machine without washing hands first or wearing gloves for > 2 minutes before placing it on a clean napkin to dry completely.</p> <p>On 3/21/13 at 4:22 P.M., LPN #10 indicated she was next going to check the blood sugar for Resident #54. LPN #10 was observed to use the same glucometer machine and the same procedure for checking the blood sugar for Resident #54. LPN #10 was then observed to use a Super Sani-Cloth Germicidal Disposable Wipe and rub the hand held glucometer machine without washing hands first or wearing gloves for > 2 minutes before placing it on a clean napkin to dry completely.</p> <p>On 3/22/13 at 10:55 A.M., LPN #6 indicated she was going check the</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents with orders for blood glucose monitoring have the potential to be affected by this finding. All Licensed nursing staff to participate in skills validations with return demonstrations. All nursing staff will continue to be required to participate in skills validations with return demonstrations upon hire, annually and as needed. These skills validations include return demonstrations related to proper cleaning and disinfecting of the glucometer machine per manufacturer's recommendation and facility policy as well as proper hand washing and appropriate use of gloves. In addition, the DNS/SDC/designee will be responsible for completing observations of nursing staff to ensure proper technique is used while cleaning and disinfecting the glucometer including use of gloves and hand washing. These observations will be conducted no less than five times per week for 3 weeks.</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>A mandatory in-service for all nursing staff will be conducted on or before 4/23/13. This in-service will be conducted by the</p>		

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	<p>blood sugar for Resident #112. LPN #6 was observed to retrieve a hand held glucometer machine, a lancet, an alcohol swab and a glucose test strip from a med cart on the 400 hall and proceed to Resident #112's room. After explaining the procedure to the resident, donning clean gloves and obtaining a blood sample for glucose reading, LPN #6 was observed to wash her hands in Resident #112's bathroom for 7 seconds before returning to her med cart. LPN #6 was observed to use a Super Sani-Cloth Germicidal Disposable Wipe and rub the hand held glucometer machine without washing hands first or wearing gloves and then wrapping it in a way where it stayed wet for 2 minutes and then placed it on a clean napkin to dry completely.</p> <p>On 3/22/13 at 11:12 A.M., interview with the Infection Control nurse (RN #11) indicated floor nurses were expected to follow facility policy and procedure for both hand washing and cleaning of glucometer machines. The Infection Control nurse was able to identify the steps of both procedures correctly and indicated it was her practice to teach staff to wash hands for 20 seconds or use alcohol based hand sanitizing gel.</p>		<p>DNS/designee. This in-service will include review of the facility policy related to proper cleaning and disinfecting of the glucometer machine per manufacturer's recommendation and facility policy. In addition, the DNS/SDC/designee will be responsible for completing observations of nursing staff to ensure proper technique is used while cleaning and disinfecting the glucometer including use of gloves and hand washing. These observations will be conducted no less than five times per week for 3 weeks. Skills validations with return demonstrations are completed upon hire, annually and as needed. These skills validations include return demonstrations related to proper cleaning and disinfecting of the glucometer machines as well as proper hand washing and appropriate use of gloves.</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: To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit tool titled, "Glucometer Testing" no less than five times per week for 3 weeks and then no less than one time per month for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be</p>				

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	<p>On 3/22/13 at 12:30 P.M., review of the current Hand Hygiene policy received from the Infection Control nurse (RN #11) dated 2/2010 and updated 3/2012 indicated "...Apply soap, rub hand together, between fingers to create a lather...use friction for at least 20 seconds...Moments of required hand hygiene: Before patient, Before an aseptic task, after body fluid exposure, after patient contact, after contact with patient surroundings...". Review of the current Glucose Meter Cleaning and Testing dated 7/2011 and updated most recently 3/2013 indicated "...2. Wash hands 3. Place paper towel, plastic cup or clean barrier on hard surface. 4. Put on gloves 5. Obtain single-use germicidal wipe, super sani-cloth. 6. Wipe entire external surface of the blood glucose meter with wipe for 2 minutes. 7. Place cleaned meter on paper towel, in plastic cup or clean barrier. 8. Allow meter to completely dry. 9. Dispose of used wipe and gloves in trash...."</p> <p>On 3/22/13 at 1:00 P.M., review of the manufacturers instructions and warnings on the Super Sani-Cloth Germicidal Disposable Wipe package received from LPN #6 on 3/22/13 at 11:00 A.M., indicated "...Disinfect and</p>		<p>submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance date = 4/24/13.</p>				

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	<p>deodorize:...Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes...Precautionary Statements: Hazards to humans...Wear suitable hand protection (e.g. gloves) when dispensing and using this product. Avoid contact with skin...."</p> <p>3.1-18(j)</p>			

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe and clean environment related to clean and soiled utility rooms, lost and found area and linen closets. This deficiency had the potential to affect 76 of 76 residents.</p> <p>Findings include:</p> <p>On 3-25-2013, during the environmental tour accompanied by the maintenance Manager and the Housekeeping Supervisor the following was noted:</p> <p>1. At 9 AM, an observation of the Clean Utility room on Heritage Hall revealed dust and dirt under the shelving units and dirt spots on the open flooring. An interview was conducted with the Housekeeping Manager indicated "...these [floors] are cleaned every day...."</p> <p>2. At 9:12 AM, an observation of the linen closet doors on Heritage Hall revealed a loud squeak to the right door when opened. The left door hinge that was located on the top left</p>	F000465	<p>F465 – Safe/Functional/Sanitary/Comfortable Environment</p> <p>It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>Clean Utility Room on Heritage Unit</i> – shelving units and floor have been thoroughly cleaned <i>Linen Closet on Heritage Unit</i> – doors have been repaired; floor has been thoroughly cleaned and waxed <i>Soiled Utility Room on Cottage Unit</i> – the hopper has been repaired <i>Lost & Found Room</i> – has been cleaned and organized and now meets the 18" clearance rule <i>Liberty Hall Clean Utility</i> – sink has been thoroughly cleaned and repaired</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	04/24/2013	

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	<p>corner was missing a fixture that was used to prevent the door itself from being harmed; a gouged out hole had been made due to opening and shutting the door. The floor was noted to be littered with filth. It was indicated that the noise from the opening and shutting of the closet doors was not pleasant.</p> <p>3. At 9:21 AM, an observation of the Soiled Utility room for Cottage Unit revealed a hopper that was not flushing. An interview with Employee #21 at this time indicated that the staff used the hopper to wash out resident's soiled clothing before sending it to the laundry. An interview with the Maintenance Director indicated that the hopper will not flush because there is not enough pressure to flush and they had plumbers in to look at the problem and there is not a solution.</p> <p>4. At 9:35 AM, an observation of Lost and Found room revealed clothing being "stored" for residents of the facility in bags above the shelves and in line with the sprinkling system. An interview with the maintenance Manager indicated that they should not store anything on the top shelves and that it was above the 18 inch clearance needed to be in compliance</p>		<p>action(s) will be taken: All residents have the potential to be affected by this finding. All Clean Utility Rooms, Linen Closets, Soiled Utility Rooms and Lost & Found Rooms have been observed for the above listed concerns and all repairs were made where needed. In addition, the facility will conduct Environmental Inspections no less than five times per week through the Customer Care Program. These Environmental Inspections will include inspections/observations of all Utility Rooms, Linen Closets and other storage areas in need of repair. Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request issues to ensure all necessary repairs and corrections have been completed. A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 4/23/13. This in-service will include review of the facility policy related to notification to the Maintenance Department and/Housekeeping Department for housekeeping issues, repairs or maintenance needs and the importance of maintaining a</p>				

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	<p>with the sprinkler system.</p> <p>5. At 9:40 AM, an observation of the clean utility room on Liberty Hall revealed rust in the sink and rusty water coming from the faucet. There was no provision to dry cleaned and wet hands.</p> <p>3.1-19(f)(1)</p>		<p>safe/functional/sanitary/comfortable environment.</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>A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 4/23/13. This in-service will include review of the facility policy related to notification to the Maintenance Department for repairs or maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment. In addition, the facility will conduct Environmental Inspections no less than five times per week through the Customer Care Program. These Environmental Inspections will include inspections/observations of all Utility Rooms, Linen Closets and other storage areas in need of repair. Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request issues to ensure all necessary repairs and corrections have been completed.</p> <p>How the corrective action(s)</p>		

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			<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with this corrective action and to ensure the environment is safe/functional/sanitary and comfortable, the ED/DNS/designee will be responsible for completion of the CQI tool titled "Quality Control Inspection-Housekeeping no less than five times per week for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Completion date = 4/24/13.</p>		