

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2012
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NAME OF PROVIDER OR SUPPLIER HILLSIDE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 E NATIONAL HWY WASHINGTON, IN 47501
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00103197 and Complaint IN00103230.</p> <p>Complaint IN00103197- Substantiated with deficiencies cited at F241, F282, F309, F312 and F314.</p> <p>Complaint IN00103230- Substantiated no deficiencies related to the allegations are cited.</p> <p>Survey dates: February 6, 7, 8, 9, and 13, 2012</p> <p>Facility number: 000303 Provider number: 155708 AIM number: 100287530</p> <p>Survey team: Melinda Lewis, RN- TC Marla Potts, RN Sharon Whiteman, RN Susan Worsham, RN (February 7, 8, 9 and 13, 2012)</p> <p>Census Bed Type: SNF: 3 SNF/NF: 35 Total: 38</p>	F0000	Please accept the following P.O.C. as Hillside Manor's credible allegation of compliance. 2-28-2012	

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>Census Payor Type: Medicare: 4 Medicaid: 30 Other: 4 Total: 38</p> <p>Sample: 10 Supplemental sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 15, 2012 by Bev Faulkner, RN</p>			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview, observation and record review, the facility failed to ensure a physician was immediately notified of a stage 2 pressure ulcer, prior to the start of a treatment, for 1 of 10 residents reviewed</p>	F0157	Hillside manor Nursing Staff shall identify and notify the attending physician and the responsible family member of any change in condition of the resident. This change could be "skin condition"	02/29/2012			

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	<p>for notification in the sample of 10. Resident C</p> <p>Findings include:</p> <p>Resident C was observed on 2/6/12 at 8:20 A.M., to have been transferred into bed. During personal care, the resident was observed to have been incontinent of urine. Her buttocks were very red, and the top of the back of her left leg was very red, with deep indentations observed from the incontinence pad. A superficial open area was observed on Resident C's coccyx. The area appeared was approximately the size of a dime with the top layer of skin missing, with minimal depth and no drainage. CNA #2 indicated she was going to go get the nurse.</p> <p>LPN #1 entered the room at 8:25 A.M., and indicated the area on Resident C's coccyx was first observed on Sunday 2/5/12. She indicated the CNA's had told her about it. She further indicated she had provided a treatment of hydrogel (a product to keep wounds moist) and applied a foam dressing over the area. LPN #1 indicated she had not gotten an order for the hydrogel or notified the physician yet, but used the hydrogel as that was what Resident C's physician normally ordered.</p>		<p>or a mental or physical change. This tag (157) was cited because a new LPN erred in her judgement to treat a superficial area on resident "C" which had been treated and healed multiple times in the past. Her error was in observation that the superficial area was scar from recent healing on 2/5 and examined on 2/6 where it now needed attention again. LPN (#1) assumed without looking that there was a standing PRN treatment. A new order was received on 2-6-12 for resident "C" that calls for a foam dressing with hydro gel to be applied daily to the coccyx area, and the foam dressing treatment shall be maintained even when no visible skin issue is detected to protect the boney prominence. This is not, by survey sample, a wide-spread problem that effected other residents. It was confined to the one resident and the one LPN. This LPN (#1) and all nursing staff was inserviced by our Medical Director on 2-10-12. His stern inservice revolved around immediate notification to him or the attending physician regarding any change in the resident.---be it skin, physical, or mental changes. The nursing staff was also admonished by the Medical Director regarding immediate implementation to any order so given. Changes: All new orders, all admissions, or readmits shall be carefully</p>		

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	<p>Resident C's clinical record was reviewed on 2/6/12 at 8:30 A.M. The clinical record lacked evidence of anyone having notified the physician of the open area.</p> <p>The clinical record indicated an entry, dated 2/6/12 at 12 noon, of the physician having been faxed and ordered hydrogel and a foam dressing. During interview with LPN #1 on 2/9/12 at 11:00 A.M., she indicated she had faxed the physician at 9:30 A.M., on 2/6/12.</p> <p>The policy and procedure for "Hillside Manor Pressure Ulcer Program," no date as to when started, included, "each resident will have their skin assessed during the scheduled shower days by the CNA responsible for their care...if a new skin condition is identified the Charge Nurse is responsible for assessing the area, obtaining measurements and documenting in the nurses notes concerning the skin condition. The charge nurse will promptly notify the physician for appropriate treatment plan as well as notify the Director of Nursing or Designee of all skin conditions..."</p> <p>3.1-5(a)(3)</p>		<p>reviewed the following morning in the AM Administrative meeting. Here, the orders shall be screened for completion, implementation, and accuracy. This shall be performed by both the administrator, the D.O.N., or her designee. The D.O.N. shall be responsible for implementation of the new procedure of screening all new orders for accuracy, complete comprehension, and implementation. This shall be a permanent ongoing procedure of Hillside Manor. The deficient practice of F157 will not occur in the future as the daily order changes are monitored by the Director of Nursing or designee and all new procedural changes/monitoring is reviewed with the Quality Assurance Committee on a Monthly basis for next 6 months.</p>		

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F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were cared for in a dignified manner which enhanced their quality of life, in that staff woke residents up in order to get them up and ready for the day, when most convenient for staff rather than as resident woke up or by their wishes, for 3 of 10 residents reviewed for dignity, in the sample of 10 and 3 of 5 in the supplemental sample of 5</p> <p>Resident G, I, C, M, H, F</p> <p>Findings include:</p> <p>1. On 2/6/12 at 4:40 A.M., the facility was observed to have hall lights on, and residents observed sitting up in the lounge area dressed for the day. Staff were observed in the process of getting residents up for the day. Resident G was observed to have been sitting up in the lounge with her head laying on her wheelchair arm sleeping. Resident H was</p>	F0241	<p>Hillside Manor shall care for the residents in a respectful and dignified manner and enhance their quality of life. The practice of awakening residents early in the AM shall not exist nor be tolerated at Hillside Manor Nursing Home. It has NEVER been a policy or request to awaken residents early in the AM for the convenience of the staff. While some residents are up very early in the AM voluntarily, no residents shall be awakened earlier than 6:00 in preparation for the 7:30AM breakfast or for physician ordered medications. The "get up" list so cited by CNA #4 was supplemented by a extra staff person who started at 6:00 AM. The 11-7 shift and supplementary CNA was to help each other with the task of toileting and dressing such between the 6AM and 7AM period before the night shift ended. All nursing staff, and all CNA's have been inserviced regarding the proper practice on 2-7-12. Hillside Manor prides itself in providing a "home-like" environment. Awakening residents who wish to sleep is not in this keeping. However, many have medication</p>	02/29/2012			

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	<p>sitting asleep in a chair with her feet up on a foot stool. Resident I was sitting in the lounge area in her wheelchair, dressed. The TV was on commercial tv and music was playing. The residents continued to sit in the lounge area until they went to the dining room at 7:30 a.m. for breakfast.</p> <p>Resident C was observed in bed at 4:40 A.M., sleeping, a shower chair was observed sitting in the doorway of her room. The light was on and the resident's roommate was fully dressed and sitting in her chair . CNA # 5 were observed to enter Resident C's room at 4:45 A.M. and awaken the resident and then dress her, CNA #4 entered the room at 4:55 a.m. to help finish dressing the resident. Resident C was then transferred to a wheelchair by CNA # 4 and CNA # 5. Resident C was then taken in the wheelchair to the lounge area of the facility.</p> <p>At 5:15 A.M., CNA #5 entered Resident M's room, turned on the overhead light and stated it's time to get up. The CNA rubbed the resident's arm waking her up and then asked the resident once she was awake, "it's time to get up, is that ok." The resident was not heard to respond, and was then provided care and dressed for the day.</p>		<p>scheduled at 6AM or before 8AM and should be taken with food. Our residents are allowed to take breakfast in thier pajamas or request the breakfast later or in their rooms. The proper protocol and compliance regarding this respect and dignity issue shall be supervised and be the responsibility of the D.O.N. who shall educate/train any new hires on the 11-7 shift. Her performance shall be monitored for the next 6 months by the QA committee.</p>				

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	<p>During the initial tour of the facility on 2/6/12 with the DON (Director of Nursing) at 5:45 A.M., she indicated Resident C, I, M and H were not interviewable and all dependant on staff for care needs.</p> <p>During interview with CNA #4 on 2/6/12 at 5:45 A.M., she indicated the facility had a "get-up list" of residents who were to be gotten up by night shift. This get-up list indicated 19 residents were to be "gotten up" by the 11-7 shift and included on this list was Residents G, I, C, and M. Eight (8) residents were to be gotten up by the 6 a.m. to 2 p.m. shift., which included Resident H, and 7 residents were independent. During interview with the Facility Administrator on 2/6/12 at 8:00 A.M., she indicated staff were not supposed to get anyone up prior to 5 a.m. and were not to awaken residents to get them up for the day.</p> <p>2. On 02/06/12 at 5:10 a.m., CNA #1 was observed to enter Resident F's room and turn the overhead light on. Resident F was observed to be abed with her eyes closed. CNA #1 was observed to approach the resident and touched the resident's hand and called the resident by name. Resident F opened her eyes,</p>			
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	<p>muttered, and went back to sleep. CNA #1 assisted the resident to sit on the side of the bed to give the resident a sponge bath. The resident was unhappy about being woken up and was complaining to the CNA. The CNA asked the resident why she was so grouchy. The resident replied, "wake somebody up out of a sound sleep."</p> <p>Review of Resident F's clinical record on 02/07/12 at 2:30 p.m., indicated the Resident had diagnoses which included, but were not limited to, Vascular Dementia, Morbid Obesity, and Psychosis.</p> <p>An annual MDS [Minimum Data Set] assessment, dated 11/24/11, indicated Resident F had poor cognition with poor decision making skills.</p> <p>During interview of the MDS Nurse on 02/08/12 at 4:45 p.m., indicated CNA's were supposed to be making rounds at 5:00 a.m. and were not supposed to be getting residents up at that time.</p> <p>This federal tag is related to Complaint IN00103197.</p> <p>3.1-3(t)</p>						

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F0282 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 and record review, the facility failed to ensure the care plan was followed for turning and repositioning Resident C every 2 hours and failed to provide pericare for Resident F per the plan of care, for 2 of 10 residents reviewed for following the plan of care, in the sample of 10.</p> <p>Findings include:</p> <p>1. Resident C was observed on 2/6/12 at 4:55 A.M., to have been dressed and transferred to a wheelchair by CNA # 4 and CNA # 5. Resident C was then taken in the wheelchair to the lounge area of the facility at this same time.</p> <p>The DON provided a CNA assignment sheet, on 2/6/12 at 6:30 A.M., which indicated the resident was to be turned every 2 hours.</p> <p>Resident C was observed to continue to sit up in the wheelchair through 8:20 A.M., without a position change (3 hours and 25 minutes) when CNA #4 and CNA</p>	F0282	Hillside Manor Nursing Home nursing staff shall provide service to the residents in accordance to the plan of care. Accidentally or intentionally not following the plan of care so transferred to the CNA assignment sheet could potentially effect all and every resident. As evidenced by the survey process this is not a standard or normal error with the entire nursing staff. Two issues are addressed here in that one resident who was at risk for possible skin break-down was not repositioned in a timely manner and another was not afforded proper peri care. Changes made to resolve the two above issues include: All nursing staff was inserviced on 2-13-12 that included following the CNA assignment sheet provided each day and each shift. All were reminded that residents at risk for a skin breakdown is to be provided a pressure relieving devices and repositioned according to the physician's plan of care. The inservice also included standard, everyday, Hillside Manor protocol regarding peri care (that includes barrier cream) following assistance with an incontinent resident	02/29/2012

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	<p>#2 wheeled the resident to her room from the dining room and transferred her into bed.</p> <p>Resident C's clinical record was reviewed on 2/6/12 at 8:30 A.M. The most recent Minimum Data Set (MDS) assessment, dated 12/1/11, indicated the resident was severely cognitively impaired with short and long term memory loss, required extensive assistance with bed mobility, transfers, was at risk of pressure ulcers with no current pressure ulcers. A care plan problem, dated 12/7/11, for "at risk for skin breakdown related to incontinence and decreased mobility," interventions included "check and change every 2 hours as needed," "barrier cream every incontinent episode and as needed," "float heels while in bed and chair," "moon boots at all times," "pressure relieving mattress to bed," "pressure cushion to chair," "notify MD of any skin problems," "turn every 2 hours."</p>		<p>(regardless of whether it is on a CNA assignment sheet or not). Proper hand washing and prevention of cross contamination was also included. Discussed was the proper removal of soiled linens/gloves/etc following peri care from the residents room. An administrative change was made from the implementation of the CNA assignment sheets. The CNA assignment sheets will be generated and updated at the time the care plan is created or the care plan is updated. This CNA assignment sheet shall be created by the D.O.N. who shall be responsible for its content and comprehensive and clear instructions to afford the proper service to the resident. The ADON will no longer be involved. The D.O.N. shall be responsible for implementation of the new CNA assignment sheets, education, supervision, and compliance with the assigned duties of the nurses and CNA's as it applies to the resident's plan of care. As this is a procedural change this monitoring and responsibility shall have no time limit. The deficient practice of F282 will not recur in the future and will be monitored by the Director of Nursing or designee. The Director of Nursing will be responsible for updating the C.N.A. Assignment Sheets over the next 6 months and this practice will be reviewed monthly by the Quality Assurance</p>		

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	<p>2. On 02/06/12 at 5:10 a.m., CNA #1 was observed to enter Resident F's room to give the resident a sponge bath. The resident was observed to have been incontinent of urine and was soaked through her gown, bed pad, and fitted sheet. The resident was observed to have deep indentations from laying on the wet pad. After washing the resident's bottom and periaarea, CNA#1 was observed to not apply barrier cream.</p> <p>On 02/06/12 at 7:22 a.m., CNA #1 and CNA #4 were observed to toilet Resident F. CNA #3 was observed to remove an adult brief from Resident #F and indicated the brief was wet. CNA #3 was observed to hand the resident a piece of toilet paper and the resident was observed to dab at her front while sitting on the commode. The CNA's were observed to not perform pericare before putting a clean brief on the resident and assisting the resident to stand and walk to the dining room.</p> <p>Review of Resident F's clinical record on 02/07/12 at 2:30 p.m., indicated the Resident had diagnoses which included, but were not limited to, Vascular Dementia, Morbid Obesity, and Psychosis.</p>		Committee.				

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NAME OF PROVIDER OR SUPPLIER HILLSIDE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 E NATIONAL HWY WASHINGTON, IN 47501
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	<p>An annual MDS [minimum data set] assessment, dated 11/24/11, indicated Resident F had poor cognition with poor decision making skills, and required extensive assistance with hygiene and bathing.</p> <p>A care plan, dated 01/06/11 with a most recent update of 04/06/11, indicated Resident F was at risk for skin breakdown due to decreased mobility and occasional incontinence and pericare and barrier cream was to be provided after episodes of incontinence.</p> <p>This federal tag relates to Complaint IN00103197.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received preventative skin care, including assessment of their skin and treatment of non pressure open areas, in that Resident D developed an open slit under her breast, which she indicated was painful and Resident F developed an open area in an abdominal skin fold, for 2 of 10 residents reviewed for skin assessments, in the sample of 10. Resident D and Resident F</p> <p>Findings include:</p> <p>1. On 2/7/12 at 10:45 A.M., Resident D was observed to be assisted to the bathroom by two nursing staff. CNA # 2 lifted Resident D's right breast. Resident D was observed to yell out when CNA # 2 lifted her breast. The area under Resident D's right breast was observed to be red from one side to the other with one end being opened. The area had a yellow, pastey substance on and around the area.</p>	F0309	Hillside Manor Nursing Home shall properly assess the resident's skin during scheduled showers and upon initial admission. Any resident found with any type of skin condition must ceceive treatment. The failure to address any issue in a timely manner may cause the area to worsen for all residents.Hillside Manor Nursing Home skin policy reporting procedure shall be changed. This new change was included within the 2-13-12 inservice for all nursing personnel. the change is from reporting "no new areas" so indicated on previous skin tool sheets to recording and reporting all and any skin conditions detected. No longer shall we work under the assumption that "this is not new" therefore it is a part of an on-going treatment plan. All skin issues shall be recorded on the skin assessment sheet. All skin conditions no matter how minor, or how repetitive shall be immediately reported to the charge nurse. All skin assessment sheets (skin tool sheets) shall be reviewed every	02/29/2012			

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	<p>The clinical record for Resident D was reviewed on 2/7/12 at 9:00 A.M. The record indicated Resident D had diagnoses that included but were not limited to diabetes and chronic kidney disease. The MDS [Minimum Data Set] assessment, dated 11/15/11, indicated Resident D had severely impaired cognition. Resident D required extensive assistance of two with transfers, ambulation, and extensive assistance of one with dressing and personal hygiene.</p> <p>A physician order, dated 1/7/11, indicated "Nystatin powder- apply to bilateral breasts and abdominal folds twice daily until healed."</p> <p>There was a care plan, dated 11/26/11, related to the resident being at risk of skin breakdown related to incontinence, but there was no care plan available related to the resident's skin condition under the breast.</p> <p>The Nurses Notes lacked any documentation since 1/18/12, and no documentation of irritated skin.</p> <p>The Director of Nursing provided a skin sheet and written documentation on 2/7/12 at 11:30 A.M. The Skin sheet indicated " 2/7/12, area under R [right] breast...12.5 across less than 0.1</p>		<p>AM by the D.O.N. (or designee) and the administrator in the daily AM administrative meeting. It shall be the responsibility of the D.O.N. (or in her absence her designee) to personally and visually inspect the cited skin condition (no matter if it has previously been reported). The D.O.N. should implement a care plan change if this is new and so adjust the CNA assignment sheet for proper care. The D.O.N. shall be responsible for monitoring this new procedure for compliance. No time limit on her participation or responsibility. She shall be responsible for interventions, reporting procedures, care plan adjustments, CNA assignment sheets, and proper out-come with treatments. The deficient practice of F309 will not recur due to the daily monitoring/reviewing of all shower sheets by the Director of Nursing or designee. This process will also be reviewed monthly for the next 6 months by the Quality Assurance Committee.</p>				

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	<p>depth...very sore especially when touch it..." The written documentation concerning this area included: "assessment of resident revealed: gualding [sic] under R breast red irritated sore open slit noted with gooey clear drainage. Measures 12 1/2 across has large pendulous breast. small area of width 0.2 at widest area of width 0.5. Cleaned area under breast with soap et water patted dry very well. Nystatin powder applied et soft pillow case, also treated. Left breast for prevention et pillow case applied."</p> <p>2. On 02/06/12 at 5:10 a.m., CNA #1 was observed to enter Resident F's room. Resident F was observed to be abed with her eyes closed. CNA #1 was observed to approach the resident and touched the resident's hand and called the resident by name.. CNA #1 assisted the resident to sit on the side of the bed to give the resident a sponge bath. The resident was observed to have a large abdominal fold. Upon request, the CNA lifted the abdominal fold. A small open slit was observed in the center of the abdominal fold. The CNA indicated, "she's opened up." CNA #1 indicated that the nurses used "Nystatin Powder" [anti-fungal powder] under the resident's abdominal fold.</p>			

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	<p>During interview of RN #1 on 02/07/12 at 1:30 p.m., RN #1 (charge nurse on the floor Resident F resided) indicated she was not aware Resident F had an open area.</p> <p>On 02/07/12 at 1:30 p.m., CNA #2 was observed to assist Resident F to sit on a commode. Upon request, RN #1 lifted the resident's abdominal fold and indicated she had not noticed the area earlier in the day when she had applied Nystatin Powder.</p> <p>Interview of the Administrator on 02/08/12 at 3:40 p.m., indicated CNA's are supposed to report any signs or symptoms of skin breakdown to the charge nurse. The Administrator also indicated Department Heads met every morning and discussed any changes or problems with residents.</p> <p>Review of Resident F's clinical record on 02/07/12 at 2:30 p.m., indicated the resident had diagnoses which included, but were not limited to, Vascular Dementia, Morbid Obesity, and Psychosis. A physician's order, which started 1/2/10, indicated "nystatin powder apply to abdominal folds TID(times daily) til healed."</p>			

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	<p>An annual MDS [Minimum Data Set] assessment, dated 11/24/11, indicated Resident F had poor cognition with poor decision making skills, and required extensive assistance with hygiene and bathing.</p> <p>A care plan, dated 01/06/11 with a most recent update of 04/06/11, indicated Resident F was at risk for skin breakdown due to decreased mobility and occasional incontinence. There was no care plan related to the resident's abdominal folds.</p> <p>The policy and procedure for "Hillside Manor Pressure Ulcer Program," no date as to when started, included "each resident will have their skin assessed during the scheduled shower days by the CNA responsible for their care...if a new skin condition is identified the Charge Nurse is responsible for assessing the area, obtaining measurements and documenting in the nurses notes concerning the skin condition. The charge nurse will promptly notify the physician for appropriate treatment plan as sell as notify the Director of Nursing or Designee of all skin conditions...."</p> <p>This federal tag relates to Complaint IN00103197.</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure services were provided as planned for residents dependent for care; as pericare and application of barrier cream was not provided for Resident F and Resident C was not checked every two hours for incontinence. This affected 2 of 5 residents reviewed for incontinence care, in the sample of 10.</p> <p>Findings include:</p> <p>1. On 02/06/12 at 5:10 a.m., CNA #1 was observed to enter Resident F's room to give the resident a sponge bath. The resident was observed to have been incontinent of urine and was soaked through her gown, bed pad, and fitted sheet. The resident was observed to have deep indentations from laying on the wet pad. After washing the resident's bottom and periarea, CNA#1 was observed to not apply barrier cream.</p>	F0312	Hillside Manor Nursing Home nursing staff shall provide service to the residents in accordance to the plan of care. Hillside Manor shall provide services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Accidentally or intentionally not following the plan of care so transferred to the CNA assignment sheet could potentially effect all and every resident. As evidenced by the survey process this is not a standard or normal error with the entire nursing staff. Three issues are addressed here in that one resident who was at risk for possible skin breakdown was not re-positioned in a timely manner and another was not afforded proper peri care in accordance to the resident's care plan and proper hygiene practices were not followed by a CNA providing toileting assistance. Changes made to resolve the above issues include: All nursing staff was inserviced on 2-13-12 that included following the CNA assignment sheet provided each day and each shift. Each resident that is at risk for a skin breakdown is to be provided a pressure relieving device and	02/29/2012			

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	<p>On 02/06/12 at 7:22 a.m., CNA #1 and CNA #4 were observed to toilet Resident F. CNA #3 was observed to remove an adult brief from Resident #F and indicated the brief was wet. CNA #3 was observed to hand the resident a piece of toilet paper and the resident was observed to dab at her front while sitting on the commode. The CNA's were observed to not perform pericare before putting a clean brief on the resident. The CNA's were observed to not wash the resident's hands before assisting the resident to stand and assisting the resident to walk to the dining room where they seated her at the dining room table for breakfast.</p> <p>Review of Resident F's clinical record on 02/07/12 at 2:30 p.m., indicated the Resident had diagnoses which included, but were not limited to, Vascular Dementia, Morbid Obesity, and Psychosis.</p> <p>An annual MDS [Minimum Data Set] assessment, dated 11/24/11, indicated Resident F had poor cognition with poor decision making skills, and required extensive assistance with hygiene and bathing and was frequently incontinent of urine.</p> <p>A care plan, dated 01/06/11 with a most recent update of 04/06/11, indicated</p>		<p>repositioned at least every 2 hours or in accordance with physician's orders. The inservice also included standard, everyday, Hillside Manor protocol regarding peri care (that includes barrier cream) following assistance with an incontinent resident (regardless of whether it is on a CNA assignment sheet or not). Proper hand washing and prevention of cross contamination was also included. Discussed was the proper removal of soiled linens/gloves/etc. following peri care from the resident room. Proper hygiene practices will be required of all staff members. Staff shall wash hands after toileting a resident before leaving the restroom. Residents shall be encouraged to do the same. An administrative change was made from the implementation of the CNA assignment sheets. The CNA assignment sheets will be generated and updated at the time the care plan is created or the care plan is updated. This CNA assignment sheet shall be created by the D.O.N. who shall be responsible for its content and comprehensive and clear instructions to afford the proper service to the resident. The ADON will no longer be involved in these responsibilities. The D.O.N. shall be responsible for implementation of the new CNA assignment sheets, education, supervision, and compliance with the assigned duties of the nurses</p>		

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	<p>Resident F was at risk for skin breakdown due to decreased mobility and occasional incontinence and pericare and barrier cream was to be provided after episodes of incontinence.</p> <p>2. Resident C was observed on 2/6/12 at 4:55 A.M., to have been dressed and transferred to a wheelchair by CNA # 4 and CNA # 5. Resident C was then taken in the wheelchair to the lounge area of the facility.</p> <p>During the initial tour and interview on 2/6/12 at 5:45 A.M., with the Director of Nursing, Resident C was identified by the Director of Nursing as having no skin issues, boots for protection to her heels, and requiring a cushion in her chair. The resident was observed to have been sitting in the lounge area at the time of the initial tour. The DON provided a CNA assignment sheet, which indicated the resident was to be turned every 2 hours and was an assist of 2 staff for incontinence care.</p> <p>The resident was observed to continue to sit up in the wheelchair through 8:20 A.M., without a position change (3 hours and 25 minutes) when CNA #4 and CNA #2 wheeled the resident to her room from</p>		<p>and CNA's as it applies to the resident's plan of care. As this is a procedural change this monitoring and responsibility shall have no time limit. The deficient practice of F312 will not recur in the future due to the Director of Nursing providing up to date C.N.A. assignment sheets. The Director of Nursing shall have the process/assignment sheets approved/reviewed monthly for the next 6 months by the Quality Assurance Committee.</p>		

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	<p>the dining room and transferred her into bed. During personal care, the resident was observed to have been incontinent of urine. Her buttocks were very red, and the top of the back of her left leg was very red, with deep indentations observed from the incontinence pad.</p> <p>Resident C's clinical record was reviewed on 2/6/11 at 8:30 A.M. The most recent Minimum Data Set, dated 12/1/11, indicated the resident was severely cognitively impaired with short and long term memory loss, required extensive assistance with bed mobility, transfers, and was incontinent of urine.</p> <p>A care plan problem, dated 12/7/11, for "at risk for skin breakdown related to incontinence and decreased mobility," interventions included "check and change every 2 hours as needed" and "barrier cream every incontinent episode and as needed."</p> <p>This federal tag relates to Complaint IN00103197.</p> <p>3.1-38(a)(3)(A)</p>			

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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received care to prevent pressure ulcers and to promote healing: in that Resident B was admitted with a pressure ulcer from a hospital stay that worsened to a Stage 3 pressure ulcer and Resident C developed a Stage 2 pressure ulcer. This deficient practice affected 2 of 4 residents reviewed for pressure ulcers in the sample of 10.</p> <p>Findings include:</p> <p>1. On 2/6/12 at 5:50 A.M., the Administrator indicated Resident B had a stage I or II pressure area on coccyx when readmitted from a recent hospitalization. Resident B was identified as interviewable and required assistant with care.</p>	F0314	<p>It is the policy of Hillside Manor Nursing Home to actively guard against the development of skin wounds and promote the healing of any that should develop. Resident B, a long time resident, had no previous issues with pressure ulcer until hospitalized. His clinical record from the hospital wound care specialist was staged at a 3, however the verbal re-admit report orders given by the discharging hospital nurse was reported as a stage 2 and so transcribed by Hillside Manor's admitting nurse. Resident C has had on/off (healed) situation with a small area on her coccyx for several months. Her area would completely heal and just as quick re-appear. Resident C since 2-7-2012 has a standing order for foam with hydrogel to be applied to the coccyx area (even after healed). LPN #1 did not perform well during the state survey and as such, she erred in applying the hydrogel treatment to resident</p>	02/29/2012			

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	<p>On 2/6/12 from 7:20 A.M. until 1:15 P.M., Resident B was observed to be sitting in a reclining chair in the lounge.</p> <p>On 2/6/12 at 1:15 P.M., Resident B was observed to be placed in bed with the assistance of LPN # 1 and CNA # 5. When Resident B was assisted to his left side, a dressing was observed on his coccyx. The dressing was dated 2/4/12. LPN # 1 indicated the dressing was supposed to be changed daily on the evening shift. Resident B was observed to be incontinent of bowel. CNA # 5 was observed to cleanse Resident B. Resident B had an area on the coccyx the approximate size of a penny. The wound bed was observed to have a yellow wound base. Both buttocks were observed and looked like the appearance of raw hamburger.</p> <p>On 2/6/12 at 1:40 P.M., in an interview with the Director of Nursing, she indicated the last time she saw Resident B's open area it was superficially open with small amount of drainage. She indicated the surrounding tissue was pink.</p> <p>On 2/6/12 at 1:45 P.M., in an interview with the Director of Nursing, she indicated the wound had a major change since she last observed the area last Wednesday.</p>		<p>C (as had been done previously) assuming there was (without verifying) a standing PRN order for such treatment. LPN also erred in changing upon her own the treatment for resident C from her day shift to the second shift without D.O.N. knowledge or approval. This nurse has been inserviced and is currently on probation. Hillside Manor has initiated a new reporting "skin tool" sheet that no longer has "no new areas" on the form. Instead, all areas both new and old are to be so recorded. The charge nurse is to be immediately notified by the CNA. The skin tool sheet is to be reviewed everyday in the following morning AM administration meeting by the D.O.N. and administrator. All wounds or indicated areas shall be visually inspected by the D.O.N. for proper treatment, care plan revisions, and healing process. Additionally, Lora Blair, RN CWS has agreed to provide monthly inspections of wounds, the progresses, and staging of such for the next 6 months. Ms. Blair provided an inservice to all nurses on 2-9-12 on proper staging of wounds. Hillside Manor's nursing staff is now required to focus on writing a detailed descriptive report of the entire wound area when assessing such, and although receiving on-going training in wound staging, focus on the content and details of the</p>				

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	<p>On 2/7/12 at 9:10 A.M., Resident B was observed to be assisted to his side. The facility Wound Specialist was present during the observation. Resident B was observed to have a half dollar size stage 2 ulcer on his right buttock, and a stage 3 on his coccyx, measured by the Director of Nursing during this observation, as 4 cm by 1.2 cm. There were 3 other superficial areas noted to the left buttock. The Wound Specialist at this time indicated the facility had received report from the hospital that Resident B had a stage 2 area on his coccyx. She stated the area should have been staged at stage 3 upon readmission to the facility instead of following the report received from the hospital.</p> <p>The clinical record for Resident B was reviewed on 2/6/12 at 10:00 A.M. The record indicated Resident B had diagnoses that included but were not limited to COPD [chronic obstructive pulmonary disease] and peripheral neuropathy. The MDS [Minimum Data Set] assessment, dated 11/28/11, indicated Resident B had modified independence with decision making. Resident B required extensive assistance of two with transfers, did not ambulate and was dependent on staff for personal hygiene. Resident B did not have a pressure sore.</p>		<p>descriptive assessment.As indicated previously, the D.O.N. shall recieve in the administrative AM meeting a complete list of all residents with any skin issues (not just new areas). It shall be the D.O.N. responsibility, or her designee, to visually look at each area that day for proper treatment procedures, timely dressing changes, pressure relieving devices in place, repositioning of the resident when required in a timely manner, and the healing process. This monitoring of the skin with the residents shall have no limits on duration. It is the new procedure. The deficient practice of F314 will not recur as the D.O.N. will monitor all skin areas and all skin policies/treatments/preventative measures/etc will be reviewed by the Quality Assurance Committttee monthly for the next 6 months.</p>				

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	<p>A "Nurses admission record and allergies examination," dated 1/14/12 at 2:30 p.m., indicated "stage 2 0.7 by 0.7 cm on coccyx." Nurses notes indicated "1/14/12- 2:30 p.m. ...readmitted...stage 2 noted to coccyx .7 c.m. by .7 c.m...."</p> <p>"1/14/12 1700 (5 p.m.) ..cleanse wounds daily with normal saline, dress with collagen, hydrogel and bordered dressing, wound assessment done."</p> <p>Wound/Skin Healing Records, indicated: "1/14/12 stage 2, 1.0 c.m. by .5 c.m., no depth, serous exudate, scant amount exudate, pink wound bed." "1/21/12 stage 2, 1.0 c.m. by .5 c.m., no depth, serous exudate, scant amount exudate, pink wound bed," "1/28/12 stage 2, 1.0 c.m. by .5 c.m., no depth, serous exudate, scant amount exudate, pink wound bed," "2/6/12 not staged, 2 by 1.5 c.m. unknown depth, serous drainage, small amount exudate, granulation tissue , coccyx with excoriation sound wound, moderate pain."</p> <p>A care plan, dated 1/16/12, indicated "Altered skin integument R/T [related to] stage 2 coccyx." The approaches were "1. Dressing chg [change] daily. Clean NS [normal saline], Apply collagen et [and] hydrogel. 2. easy boots for feet protection. wear at all times except for ADL's</p>			
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	<p>[activities of daily living]. 3. Notify Dr of ill effects. 4. measure coccyx wound weekly."</p> <p>On 2/7/12 at 1:30 P.M., the Director of Nursing provided the wound measurements for Resident B. "Coccyx 4 x [by] 1.2 x 0.2 depth, Stage 3. 50% granulation 50% slough with a thin layer of DTI [deep tissue injury] noted on the LTA [left] edge. Area is 2 wounds with a .2 cm bridge noted between both wounds. Periwound intact with slight redness noted. Recommend treatment change to Santyl to slough and collagen to granulation. Barrier cream to periwound. LT buttock 4 x 2 x < [less than] .2 depth Stage 2 Pale pink wound bed. Periwound intact. Hydrogel to wound bed. Barrier cream to periwound. RT [right] buttock 2 x 1 x <.2 Stage 2 Pale pink wound bed. Periwound intact Hydrogel to wound bed. Barrier cream to periwound."</p> <p>2. Resident C was observed on 2/6/12 at 4:55 A.M., to have been dressed and transferred to a wheelchair with a pressure reducing cushion, by CNA # 4 and CNA # 5. Resident C was then taken in the wheelchair to the lounge area of the facility.</p> <p>Resident C was identified by the Director of Nursing, this same day, on the initial</p>			

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	<p>tour of the facility at 5:45 A.M. as having no skin issues, boots for protection to her heels, and requiring a cushion in her chair. The resident was observed to have been sitting in the lounge area at the time of the initial tour.</p> <p>The Director of Nursing provided a CNA assignment sheet on 2/6/12 at 6:30 A.M., which indicated the resident was to be turned every 2 hours.</p> <p>The resident was observed to continue to sit up in the wheelchair through 8:20 A.M. without a position change (3 hours and 25 minutes) when CNA #4 and CNA #2 wheeled the resident to her room from the dining room and transferred her into bed. During personal care, the resident was observed to have been incontinent of urine. Her buttocks were very red, and the top of the back of her left leg was very red, with deep indentations observed from the incontinence pad. A superficial open area was observed on Resident C's coccyx. The area was approximately the size of a dime with the top layer of skin missing, but minimal depth and no drainage. CNA #2 indicated she was going to go get the nurse.</p> <p>LPN #1 entered the room at 8:25 a.m., and indicated the area on Resident C's coccyx was first observed on Sunday</p>			

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	<p>2/5/12 , and CNA's had told her about it. She further indicated she had provided a treatment of hydrogel (a product to keep wounds moist) and applied a foam dressing over the area. LPN #1 indicated she did not know when the dressing had fallen off or been removed. LPN #1 indicated she had not gotten an order for the hydrogel or notified the physician yet, but used the hydrogel as that was what Resident C's physician normally ordered. She further indicated she had not measured the area or documented it.</p> <p>During interview the Director of Nursing, on 2/6/12 at 8:30 A.M., she indicated Resident C did not have any open areas last Wednesday when she did wound rounds, and was not aware the resident had an open area.</p> <p>Resident C's clinical record was reviewed on 2/6/12 at 8:30 A.M. The most recent Minimum Data Set, dated 12/1/11, indicated the resident was severely cognitively impaired with short and long term memory loss, required extensive assistance with bed mobility, transfers, was at risk of pressure ulcers with no current pressure ulcers. A care plan problem, dated 12/7/11, for "at risk for skin breakdown related to incontinence and decreased mobility," interventions included "check and change every 2 hours</p>			

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	<p>as needed," "barrier cream every incontinent episode and as needed," "float heels while in bed and chair," "moon boots at all times," "pressure relieving mattress to bed," " pressure cushion to chair," "notify MD of any skin problems," "turn every 2 hours."</p> <p>The wound sheets, dated 2/6/12, indicated a "stage 2" "1 by .5 cm," no exudate, pink wound bed, plan of care, hydrogel and collagen foam dressing, no pain.</p> <p>The policy and procedure for "Hillside Manor Pressure Ulcer Program," no date as to when started, included, "each resident will have their skin assessed during the scheduled shower days by the CNA responsible for their care...if a new skin condition is identified the Charge Nurse is responsible for assessing the area, obtaining measurements and documenting in the nurses notes concerning the skin condition. The charge nurse will promptly notify the physician for appropriate treatment plan as well as notify the Director of Nursing or Designee of all skin conditions..."</p> <p>This federal tag relates to Complaint IN00103197.</p>			

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	3.1-40(a)(1) 3.1-40(a)(2)			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to recognize symptoms of a possible urinary tract infection and then failed to obtain a urine specimen in a timely fashion for Resident H, and failed to obtain a urinary specimen timely for Resident G, in order to provide prompt treatment for urinary tract infections, for 1 of 5 residents reviewed with a urinary tract infection, in the sample of 10, and 1 of 1 supplemental residents reviewed for urinary tract infections, in the supplemental sample of 5.</p> <p>Resident G and H</p> <p>Findings include:</p> <p>1. Resident H was identified on the initial tour of the facility on 2/6/12 at 5:45 A.M., by he Director of Nursing (DON) as</p>	F0315	Hillside Manor Nursing Home shall provide immediate, prompt and appropriate services and treatment to prevent urinary tract infections and restore normal bladder function.Prompt UA was not obtained by LPN #1 on both resident H and resident G. While this deficient practice did effect two residents, it most fortunately is not a practice, policy, or bad habit of the rest of the nursing staff. LPN #1 has been placed on probation and recieved education. The medical director inserviced all nurses on 2-10-12 on immediate intervention to any physician's orders.A change in nursing practice was implemented by Hillside Manor in that any orders received by any nurse must be resolved and in place before the end of their shift. They may not pass on to the next shift any "dangling" new orders. New med orders on one shift and not yet delivered by the pharmacy at shift end is not included as an	02/29/2012

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	<p>cognitively impaired, no recent falls, walks with a walker and assist of staff. Diagnoses included, but was not limited to, a history of UTI's. (urinary tract infections)</p> <p>Resident H's clinical record was reviewed on 2/8/12 at 10:00 A.M.</p> <p>Nurses notes indicated: "1/23/12 resident has been very restless since 1 PM today...keeps yelling out 'I'm sick or I need to go to the bathroom'...res taken to bathroom 8 times resident urinated 2 times...." "1/26/12 6:40 p.m. very anxious...screaming I'm sick..." "1/28/12 220 A res...hollering for help...incontinent of urine...complained of bottom hurting..." "2/2/12 3 a.m. pt complains of stomach ache..." "2/2/12 730 p.m. Dr faxed regarding increased behaviors" "2/3/12 0330 received new orders to obtain UA in am and to given 1 mg Ativan now."</p> <p>A telephone physicians order, dated 2/3/12, indicated "give 1 mg Ativan now (antianxiety medication)" and "get UA (urinalysis) in A.M."</p> <p>The Urinalysis report, dated 2/7/12, indicated abnormal results of "Appearance- hazy (normal reference range- clear), 1 + leukocytes (normal</p>		<p>un-resolved order. All new physician orders are to be presented to the D.O.N. or her designee, for review in the following AM administrative meeting. The new orders shall be reviewed by the D.O.N. for completion, which would include any new lab/UA orders. The D.O.N. shall assume total responsibility for monitoring the completion and timeliness of any new order so given by a physician. This practice shall be on-going and shall no time limit of expiration. The deficient practice of F315 will not recur as the Director of Nursing will review all labs/orders daily for completion. The results of this monitoring must be reviewed monthly by the Quality Assurance Committee for the next 6 months.</p>		

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	<p>negative), positive nitrites (normal negative), white blood cells 50-100 (normal 0-2), casts-few hyaline, (normal none seen), bacteria-many (normal none seen). Culture status, C&S set up -indicated. A telephone physician order indicated an antibiotic was ordered 2/7/12 at 5 p.m.</p> <p>During interview with the DON on 2/9/12 at 10:00 A.M., she indicated she did not know why the UA was not obtained until 2/7/12, when it was ordered on 2/3/12.</p> <p>2. Resident G was identified on the initial tour of the facility on 2/6/12 at 5:45 A.M., as cognitively impaired and requiring a wheelchair for mobility. The resident was observed at the time of the tour to have been sitting up in a wheelchair in the lounge area of the facility, with her head laying over onto the arm rest of the chair. The resident appeared to be sleeping.</p> <p>Resident G's clinical record was reviewed on 2/7/12 at 9:30 A.M. A telephone physician order indicated "1/23/12 at 5 p.m. obtained UA (urinalysis) and C&S (culture and sensitivity) if indicated." Diagnose included but were not limited to, "History of Urinary Tract Infections."</p>				

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	<p>Nurses notes, dated 1/16/12, indicated the resident was on antibiotics for congestion, the next entry was "1/23/12 5 p.m. new order for ua with C&S in indicated." The next entry was 1/26/12 at 12 noon, "urine results here medical doctor aware and placed on chart. "</p> <p>The urinalysis, dated 1/27/12, indicated "collected 1/26/12" and abnormal results were "hazy (normal clear), 2 plus leukocytes (normal reference range negative), positive nitrites (normal range negative), trace blood (normal negative), white blood cells 25 to 50 with normal 0-2, red blood cells 3-5 with normal 0-2, many bacteria, with normal none seen."</p> <p>During interview with the DON (Director of Nursing) on 2/7/12 at 11:00 A.M., she indicated she did not know why the urine specimen, for the UA ordered on 1/23/12 was not obtained until 1/26/12.</p> <p>A telephone physician's order indicated 1/27/12 9 a.m., "Cipro 500 mg one po (orally) times 5 days, diagnosis urinary tract infection."</p> <p>The culture and sensitivity, collected 1/26/12, released 1/28/12 12:55 p.m., and faxed 1/29/12 11:01 a.m., indicated the organism causing the infection was sulfa resistant e coli in urine, and was not</p>						

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	<p>susceptible to cipro, but was susceptible to Macrobid.</p> <p>A telephone physician order, dated 1/30/12, indicated to discontinue the Cipro, and start "Macrobid 100 mg one po (orally) times 5 days." The resident went 7 days from the initial order for a UA on 1/23/12 until an antibiotic was ordered which would be affective against the organism causing the urinary tract infection.</p> <p>3.1-41(a)(2)</p>			

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident admitted with a gastrostomy tube (g-tube) had a plan in place to ensure services to prevent complications were provided, in that Resident #24 was admitted with an order for feeding but lacked any plan to meet the hydration needs of the resident, for 1 of 1 residents reviewed with a G-tube in the sample of 10.</p> <p>Findings include:</p> <p>LPN #1 was observed on 2/7/12 at 9:10 A.M., to set up and administer medications to Resident #24 per the G-tube. She checked placement and flushed the tube before and after the medications with 120 cc of water. LPN #1 indicated at that time she was using 120 cc of water.</p>	F0322	Hillside manor Nursing Home shall always meet the hydration needs of the residents. Relative to this tag, Hillside Manor shall assure that the hydration of a G-tube fed resident is proper and in accordance to the physician's orders.LPN #1 did not accept a complete order from the physician regarding the G-tube feeding. A nurse has to know what to expect in an order for such and question the physician until proper and complete order for hydration is addressed. This nurse was following the MAR sheet of 60cc before and after, however was charting that she was giving 120cc to flush before and after--both without a complete physician's order to do so. The complete physician's order was obtained on 2-7-12 which indicated the G-tube should be flushed with 60cc of water. This was the only resident found without proper and complete order, therefore it did not effect all residents.An inservice was held by the inservice director, B.Helm	02/29/2012			

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	<p>The clinical record for Resident #24 was reviewed on 2/7/12 at 10:00 A.M. Admission physician orders, dated 2/3/12, included an order for "NPO (nothing by mouth)" and "Pulmocare tube feeding 5 cans daily via G-tube." All medications indicated they were to be administered per the feeding tube. The orders did not include the amount of water to be administered in the feeding tube.</p> <p>Nurses notes indicated: "2/3/12 3:30 p.m. Resident arrived...confused most of time...." "2/3/12 6 p.m. ...gave pulmocare 237 ml through tube feeling, flushed with 20 cc water, handled well..." "2/4/12 1840 (8:40 p.m.)...g tube patent, placement verified, flushes easily..." "2/5/12 1 a.m. ...gt (g-tube) flushes well..." "2/5/12 2 p.m....alert with confusion...g-tube patent flushes well..." "2/6/12 6 p.m....abd soft and non-distended, g-tube in place for feeding of pulmocare checked for placement prior to feeding...."</p> <p>During interview with LPN #1 on 2/7/12 at 11:30 A.M., she indicated she flushed before and after medications with 120 cc water. She indicated she would have documented this in nurses notes. She further indicated she was aware there was no order for a water flush from the physician.</p>		<p>RN BSN for all nurses on 2-15-12 on what would/should be a complete order for a G-tube patient. Included was expectations of an order to crush any non-liquid meds, proper placement of tube, amount of water to flush before and after meds, and meals and also care of the actual site. This inservice above followed the inservice held by our medical director on 2-10-12 which also emphasized to the nursing staff about taking complete orders and knowing in advance what to expect. A new Hillside Manor procedure so indicated in previous tags should aid in the resolve of this issue of not accepting a complete order. All new orders are to be presented the following AM to the D.O.N. or her designee, in the administrative meeting where by the content of the physician's orders can be re-evaluated for completeness and accuracy. Therefore, the D.O.N. shall accept responsibility for compliance. This new procedure shall have no time limit and shall be on-going. The deficient practice of F322 will not recur as all g-tube or feeding tube orders will be reviewed by the Medical Director and Director of Nursing. The Director of Nursing will report all feeding tube orders to the Medical Director (President of Quality Assurance Committee). The Quality Assurance Committee shall review all orders</p>				

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	<p>The clinical record was reviewed again on 2/13/12 at 7:30 A.M. A nurses note entry indicated: "2/7/12 at 11:00 A.M....gtube patent, flushed with 120 cc water, pulmocare given then flushed with 120 cc water, no edema..."</p> <p>A telephone physician order, dated 2/7/12 at 11:55 A.M., indicated an order for "g-tube flushes before feedings with 60 cc water, after feedings flush with 60 cc water" and "g-tube flush when administered medications 60 cc before liquid medications and medications that has been crushed and flush with 60 cc after medication has been given..."</p> <p>The inservice director, provided a part of the facility policy for g-tubes, on 2/7/12 at 11:30 A.M., which she had inserviced staff in March 2011 on. The partial policy indicated "Administering Meds via Tube Feedings," Feeding tubes shall be rinsed using a 60 ml syringe with at least 20-30 cc water before and after giving medications..." During interview with the Health Facility Administrator, on 2/13/12 at 7:30 A.M., she indicated the facility could not find a current policy and procedure for G-tubes.</p> <p>3.1-44(a)(2)</p>		monthly over the next 6 months.				

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure staff handled</p>	F0441	Hillside Manor shall maintain a safe and sanitary environment	02/29/2012	

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	<p>linens properly (Resident #9), failed to ensure residents and staff hands were washed following personal care (Resident F) and failed to ensure a nurse washed their hands and changed gloves between administering g-tube medications and eye drops (Resident #24). This affected 2 of 10 residents reviewed for infection control measures in the sample of 10, and 1 of 5 supplemental residents reviewed for infection control in the supplemental sample of 5.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 02/06/12 at 5:30 a.m. CNA #1 was observed to provide a sponge bath for Resident #9. After washing the resident's face, hands, and back, the CNA was observed to drop the wash cloth on the floor. The CNA was observed to pick up the wash cloth from the floor and placed it on the resident's over-the-bed table where the resident's drink cup was placed. On 02/06/12 at 7:22 a.m., CNA #3 and CNA #4 were observed to assist Resident F to the bathroom using a gait belt. The CNA's were observed to pull the resident's slacks down and to assist the resident to sit on the commode. CNA #3 was observed to remove a wet brief and throw it in the trash. CNA #4 was observed to hand the resident some toilet 		<p>that prevents the development or transmission of disease and infections. All residents could be effected by improper and poor execution of safe and sanitary protocols for handwashing and/or proper use of gloves. A comprehensive inservice was held for all nursing and laundry personnel on 2-13-12 by our inservice director on timely and proper techniques in handwashing and glove usage. The inservice included techniques to prevent cross-contamination by improper linen handling/transportation; the supplies and techniques needed to provide proper bed baths and toileting techniques. An inservice was provided for the nurses on the safe and sanitary acceptable practices during treatments or administration of medicines (such as cited eye drops). It was pointed out that when in doubt - always wash hands. Also included was the demand for toileted residents to wash their hands equally along with the staff. The inservice director shall monitor for cross contamination and proper handwashing techniques for laundry personnel, nurses, and CNA's. She shall spot check and visually observe weekly toileting techniques in/during treatments or administration of medications. This monitoring shall extend for the next 6 months with any non compliance reported to the</p>				

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	<p>tissue. The resident was observed to dab at her front while seated on the commode. The CNA's were observed to not wash their hands, or the resident's hands before exiting the bathroom and seating the resident at the dining room table for breakfast.</p> <p>A "Handwashing" policy (not dated) was provided by the Administrator on 02/09/12 at 9:40 a.m. The policy indicated, "The facility will provide guidelines and approved supplies to all employees for proper and appropriate handwashing techniques that will aid in the prevention of the transmission of infections....Approved liquid soap and dispensers will be provided for all employees for handwashing while on duty. Approved waterless antiseptic wash will be provided to all employees for adjunct to handwashing. The use of gloves does not replace handwashing...When to wash hands. Upon reporting to work...after contact with blood, body fluids, secretions, excretions, mucous membranes, or broken skin...after removing gloves...after using the toilet..."</p> <p>2. On 2/7/12 at 9:15 am, LPN#1 was observed to enter Resident #24's room with medications and eye drops. LPN #1 donned gloves. She then proceeded to</p>		<p>administrator. The administrator shall be ultimately responsible for proper compliance to safe and sanitary techniques. The deficient practice of F441 will not recur as the Quality Assurance Committee will review the infection control log monthly for the next 6 months.</p>		

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	<p>administer the medications per the G-tube and flush the tube with water. LPN #1 then returned the syringe she had used to administer the medications and water to its package. LPN#1 then proceeded to push residents bedside table out of her way, with gloves still on, bending over to get a Kleenex from Residents #24's dresser. LPN#1 then proceeded to instill eye drops into both of Resident #24 eyes with same gloves on. After instilling eye drops, LPN#1 removed gloves, picked up eye drop bottle and proceeded to exit out of Resident#24 room.</p> <p>The Geriatric Medication Handbook, Eighth Edition, indicated for Eyedrop administration, "wash hands, examination gloves may be worn,...instill medication...recap bottle, wash hands..."</p> <p>3.1-18(l) 3.1-19(g)(1)</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure clinical records were complete, in that Resident C developed a pressure area that was not documented at the time it was discovered, for 1 of 10 residents reviewed for complete and accurate clinical records in the sample of 10.</p> <p>Findings include:</p> <p>Resident C was observed on 2/6/12 at 8:45 A.M., to have been placed into bed. During personal care, the resident was observed to have been incontinent of urine. Her buttocks were very red, and the top of the back of her left leg was very red, with deep indentations observed from the incontinence pad. A superficial open area was observed on Resident C's</p>	F0514	Hillside Manor Nursing Home shall document immediately any resident condition change. This was not complied with by LPN #1 who when notified of resident C's change provided treatment as previously ordered by her physician without verifying it was not a standing PRN order. Because this issue seems to be isolated to LPN #1, there is belief this is not a common or wide-spread practice that effects all residents. This tag and related problems identical to F157 and F314 previously addressed. LPN #1 will comply with Hillside Manor and practical nursing standards. As this failure in proper nursing protocol is confined to this one LPN, it did not effect all residents. Because of the number of times the superficial area on resident C's coccyx area has appeared/disappeared the physician has on 2-7-12 issued a	02/29/2012			

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	<p>coccyx. The area was approximately the size of a dime with the top layer of skin missing, but minimal depth and no drainage. CNA #2 indicated she was going to go get the nurse.</p> <p>LPN #1 entered the room at 8:25 a.m., and indicated the area on Resident C's coccyx was first observed on Sunday 2/5/12 and CNA's had told her about it. She further indicated she had provided a treatment of hydrogel (a product to keep wounds moist) and applied a foam dressing over the area. LPN #1 indicated she did not know when the dressing had fallen off or been removed. LPN #1 indicated she had not gotten an order for the hydrogel or notified the physician yet, but used the hydrogel as that was what Resident C's physician normally ordered. She further indicated she had not measured the area or documented it.</p> <p>Resident C's clinical record was reviewed on 2/6/12 at 8:30 A.M. The clinical record lacked evidence of documentation of the open area.</p> <p>The policy and procedure for "Hillside Manor Pressure Ulcer Program," no date as to when started, included ""each resident will have their skin assessed during the scheduled shower days by the CNA responsible for their care...if a new</p>		<p>standing order for a foam dressing to be maintained. This nurse along with all nurses were, as previously cited, were inserviced on 2-10-12 by our medical director on immediate and prompt reactive interventions to any physician orders. As previously cited, a new policy changes the skin tool reporting sheet to one that does not include the language "no new areas". Additionally, a policy change for nurses prohibit a nurse from taking a physician's order and not having implemented the order before shift end. As previously indicated, all new orders shall be reviewed by the D.O.N., or her designee, in the following AM administrative meeting to assure completion and timeliness of any orders given or any reported skin issues. The D.O.N. shall, therefore be responsible for proper compliance, timeliness, and nursing practices of the nursing staff. This on-going supervision and monitoring shall have no time limit. The QA committee shall monitor the over-all performance of the daily administrative review for skin issues and proper nursing protocols.</p>		

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	<p>skin condition is identified the Charge Nurse is responsible for assessing the area, obtaining measurements and documenting in the nurses notes concerning the skin condition."</p> <p>3.1-50(a)(1)</p>			