

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2012
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NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN47670
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F0000	<p>This visit was for a Recertification and State licensure survey.</p> <p>Survey dates: January 9, 10, 11, 12, 2012</p> <p>Facility number: 000036 Provider number: 155093 AIM number: 100269640</p> <p>Survey team: Amy Winger, RN, TC Barb Fowler, RN Vickie Ellis, RN</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicare: 8 Medicaid: 18 Other: 8 Total: 34</p> <p>Sample: 10</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/17/12 Cathy Emswiler RN</p>	F0000	<p>Submission of this plan of correction shall not constitute or be construed as an admission by this facility that the allegations in this survey report are accurate or reflect accurately the provision of nursing care and service to the residents of Gibson General Hospital SNF.</p> <p>This facility requests that the following plan of correction be considered its allegation of compliance.</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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F0314 SS=G	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents at risk for developing a pressure ulcer, but admitted without a pressure ulcer were turned and repositioned resulting in the resident's developing a pressure ulcer, for 2 of 4 sampled residents with a pressure ulcer in a sample of 10, in that Resident #23 was admitted without a pressure ulcer and developed a Stage III pressure ulcer with slough on the coccyx and Resident #20 was admitted without a pressure ulcer and developed a Stage III pressure ulcer with slough in the sacral area, without preventive measures in place.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #23 was reviewed on 1/11/12 at 10:00 A.M. The record indicated Resident #23 was admitted on 12/10/11. The December 2011 Physician's Orders recap indicated</p>	F0314	<p>F314</p> <p>1. Each of the records for pressure areas for the residents cited was reviewed by the DON and the nurse designated to do wound care. Resident # 20 was examined thoroughly and a reassessment done of the skin areas. An updated care plan was written. Resident # 23 was on the acute care unit in the hospital at the time of the survey; she was transferred to another hospital from the acute care unit and did not return to our unit so no reassessment was able to be completed.</p> <p>2. Any resident who currently has any skin areas or is at risk of developing areas, was reassessed. A new Braden scale was completed on each one. Care plans were also reviewed and updated.</p> <p>3. All policies and forms related to pressure or skin areas were reviewed by the DON. Revisions were made to both the policies and the forms. The Braden scale will be completed x 4 weeks post admit on</p>	01/23/2012

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	<p>the diagnoses of Resident #23 included, but were not limited to, Arthritis, Pain in Left Shoulder, and Left Chronic Shoulder Dislocation.</p> <p>Upon interview during the initial tour on 01/09/12 at 9:50 A.M. the MDS [Minimum Data Set Assessment] Coordinator indicated she was responsible for wound management. She further indicated, at that time, Resident #23 was interviewable, repositioned herself in bed without assistance, and had a Stage III wound on the coccyx. She further indicated Resident #23 had been "...admitted with redness, that wound was facility acquired..." At that time, Resident #23 was observed to be in bed, lying on her back, with a sling on the left arm.</p> <p>On 01/09/12 at 12:15 P.M. Resident #23 was observed to be in bed, lying on her back, with a sling to the left arm. During an interview at that time, Resident #23 indicated, "I've just been lying here this morning...nobody helped me turn, I can't do it myself..."</p> <p>On 01/09/12 at 2:30 P.M. Resident #23 was observed to be in bed, lying on her back, and with a sling to the left arm. During an interview at that time, Resident #23 indicated, "I don't feel good, I sat up for a bit and then laid back down."</p>		<p>all residents. All the revisions were presented to staff at an inservice on January 23, 2012. (Attachments A – G)</p> <p>4. The Director of Nursing will monitor as follows: She will do checks daily with the wound nurse for anyone who has a new pressure area. The nurse designated to do wound care will complete the assessment, do care plan implementation (including preventative measures), appropriate treatment, completion of skin records, and documentation on Kardex. The "Turn" schedules noting the frequency of repositioning of the residents, will be reviewed randomly once a week by the DON for a period of one year to check for completion and accuracy. The documentation on the pressure areas will be audited by the DON for accuracy and completeness and will be discussed with staff at the monthly inservice with recommendations for improvement; the overall result of the audits will be reported at quarterly PI for a period of one year.</p>		

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	<p>During an interview with the Health Facility Administrator [HFA] on 01/10/12 at 8:20 A.M. she indicated, Resident #23 had been "sent to ER [Emergency Room] with nausea and vomiting"</p> <p>The most recent MDS dated 12/16/11 indicated Resident #23 had no cognitive impairment and required extensive assistance of two staff for bed mobility.</p> <p>The Initial Interview Report dated 12/10/11 indicated, "Decubitus Ulcer: No problem upon admission...Supportive Devices Used:...Has sling on left arm..."</p> <p>The "Braden Scale-for Predicting Pressure Sore Risk" dated 12/21/11 indicated Resident #23 was a mild risk for developing pressure sores with a score of 16. The assessment tool further indicated, "Mobility...Very limited-makes occasional slight changes in body or extremity position but unable to make frequent or significant changes interdependently..." The assessment tool lacked any documentation that an assessment of Resident #23 risk for developing a pressure sore had been performed since 12/21/11.</p> <p>The "West End Assignment Sheet" dated 01/09/12 was provided by the MDS</p>			

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	<p>[Minimum Data Set Assessment]</p> <p>Coordinator on 01/09/12 at 10:00 A.M. The Assignment Sheet lacked any documentation that Resident #23 was to be assisted with turning and repositioning or was at risk for pressure.</p> <p>The Usual Conditions/Status Form provided by the DoN [Director of Nursing] on 01/12/12 at 9:00 A.M. indicated, "Range in Motion Upper Extremity-Impairment Both Sides."</p> <p>An undated Initial Care Plan indicated, "Pressure Sore...Prevention:...Positioning: q 2 hours..."</p> <p>A Care Plan dated 12/21/11 identified a problem of "Resident is at risk for skinbreak [sic] down: ...O.A. [open area] on coccyx" The Approaches included, but were not limited to, "1. Ensure resident has been turned as scheduled...SRS [siderails] for positioning with assist..."</p> <p>A Care Plan dated 01/06/12 identified a problem of "Stage III coccyx". The approaches included, but were not limited to, "...5. T/R [turn and reposition] q [every] 2 [two] hours and prn [as needed] with assist of 1 [one]."</p> <p>The Wound/Skin Record indicated a Stage II wound [partial thickness loss of</p>				

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	<p>skin] measuring 0.2 X 0.5 X less than 0.1 cm [centimeter] was observed on 12/22/11. The record further indicated the wound was observed on 12/29/11 to be a Stage III wound [full thickness tissue loss] measuring 2.4 X 1.0 X 1.0 cm.</p> <p>A Nursing Note dated 12/22/11 at 9:30 A.M. indicated, "...Reported area on coccyx...Has waffle cushion in chair and w/c [wheelchair]. Panacea mattress on bed. Repositioned s/s [side to side]..."</p> <p>During an interview with the DoN on 01/11/12 at 11:00 A.M., she indicated Resident #23 did not have an Activities of Daily Living [ADL] turning sheet and she could not provide evidence Resident #23 had been turned and repositioned from 12/21/11 through 01/11/12. The DoN further indicated, Resident #23 had "declined and was not re-assessed...I was not aware it took two [staff] to turn her..."</p> <p>2. The clinical record of Resident #20 was reviewed on 1/11/12 at 12:45 P.M. The record indicated Resident #20 was admitted on 12/21/11.</p> <p>Upon interview during the initial tour on 01/09/12 at 10:05 A.M. the MDS Coordinator indicated Resident #20 was interviewable and had a "Stage II wound on the left gluteal...that wound was</p>				

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	<p>facility acquired..." At that time, Resident #23 was observed to be sitting in his personal recliner.</p> <p>On 01/09/12 at 12:15 P.M. Resident #20 was observed to be sitting upright in a recliner next to the bed.</p> <p>On 01/09/12 at 2:30 P.M. Resident #20 was observed to be sitting upright in a recliner with his eyes closed.</p> <p>On 01/10/12 at 8:20 A.M. Resident #20 was observed to be lying in bed on his back.</p> <p>On 01/10/12 at 10:30 A.M. Resident #20 was observed to be sitting upright in a recliner next to the bed.</p> <p>On 01/10/12 at 2:30 P.M. Resident #20 was observed to be sitting upright in a recliner with a bedside table in front of him.</p> <p>The December 2011 Physician's Orders recap indicated the diagnoses of Resident #20 included, but were not limited to, COPD [Chronic Obstructive Pulmonary Disease], H/O [history of] Renal Insufficiency, Hypertension, and Right Upper Lobe Pneumonia.</p> <p>The Initial Interview Report dated 12/21/11 indicated, "Skin Integrity: Reddened area to buttocks</p>						

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	<p>area...Decubitus Ulcer: No problem upon admission..."</p> <p>The "Braden Scale-for Predicting Pressure Sore Risk" dated 12/21/11 indicated Resident #20 was a risk for developing pressure sores with a score of 19. The assessment tool lacked any documentation that an assessment of Resident #20 risk for developing a pressure sore had been performed since 12/21/11.</p> <p>The most recent MDS dated 01/03/12 indicated Resident #20 had cognitive impairment and required extensive assistance of one staff for bed mobility.</p> <p>The "West End Assignment Sheet" dated 01/09/12 was provided by the MDS Coordinator on 01/09/12 at 10:00 A.M. The Assignment Sheet lacked any documentation that Resident #20 was to be assisted with turning and repositioning or was at risk for pressure.</p> <p>The Usual Conditions/Status Form provided by the DoN on 01/12/12 at 9:00 A.M. included, but was not limited to, an unsigned, handwritten note dated 01/01/12 that indicated, "Side to side teaching done for Resident et [and] wife at bedside due to coccyx/buttocks...voiced understanding however, Res. [Resident] unable to retain side lying position more</p>				

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	<p>than 30 [illegible]. Wife told staff to turn Res. on back."</p> <p>A Care Plan dated 12/26/11 identified a problem of "Resident has 2 [two] small open areas on coccyx and left buttocks due to incontinent episodes" The Approaches included, but were not limited to, "1. Ensure resident has been turned...10. Uses SRS to turn self with assist."</p> <p>During an interview with the MDS Coordinator on 01/12/12 at 9:45 A.M. she indicated there was not a care plan specifically for the pressure area on the gluteal cleft.</p> <p>A Care Plan dated 12/21/11 identified a problem of "Resident is at risk for skinbreak [sic] down: ...O.A. [open area] on coccyx" The Approaches included, but were not limited to, "1. Ensure resident has been turned as scheduled...SRS [siderails] for positioning with assist..."</p> <p>A Care Plan dated 01/04/12 identified a problem of "Resident is at risk for skinbreak [sic] down:..r/t ...sit straight up." The approaches included, but were not limited to, 1. Ensure resident has been turned as scheduled..."</p> <p>The Wound/Skin Record for a Stage II</p>				

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	<p>wound located on the "gluteal cleft-sacral" indicated the initial wound measurement were "1.0 X 0.2 X less than 0.1 cm". The next entry dated 01/06/12 indicated the wound had deteriorated to a Stage III measuring 1.2 X 0.8 X [no depth indicated]. The Wound/Skin Records further indicated Resident #20 had two additional Stage II wounds located on the "left gluteal".</p> <p>The January 2012 Turn and Reposition Record provided by the DoN on 1/11/12 at 2:00 P.M. indicated Resident #20 was positioned on his back or in a chair on:</p> <p>January 2, 2012 from 6:00 A.M. to 12:00 P.M. [Six hours]            January 3, 2012 from 6:00 A.M. to 12:00 P.M. [Six hours]            January 4, 2012 from 6:00 A.M. to 12:00 P.M. [Six hours]            January 5, 2012 from 6:00 A.M. to 10:00 A.M. [Four hours]            January 6, 2012 from 6:00 A.M. to 8:00 P.M. [Fourteen hours] and 12:00 P.M. to 2:00 A.M. [Fourteen hours] on January 7, 2012.            January 7, 2012 from 6:00 A.M. to 12:00 P.M. [Six hours] and 4:00 P.M. to 8:00 P.M. [Four hours]            January 8, 2012 from 6:00 A.M. to 12:00 P.M. [Six hours] and 4:00 P.M. to 8:00 P.M. [Four hours]            January 9, 2012 from 6:00 A.M. to 8:00</p>			

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	<p>P.M. [Fourteen hours] January 10, 2012 from 8:00 A.M. to 2:00 A.M. on January 11, 2012. [Eighteen hours]</p> <p>In an interview with the DoN on 01/12/12 at 9:45 A.M. she indicated, "I told the CNA's [Certified Nursing Assistants] that the residents can't be on their bottoms for that long, when I saw that documentation yesterday."</p> <p>During an interview with the MDS Coordinator and the DoN on 01/11/12 at 11:10 A.M. the MDS Coordinator indicated, "Stage III on gluteal cleft? How it could be a III, I have no idea..." At that time the DoN indicated, "[name of attending physician] called it a Stage II but, she [the MDS Coordinator] called it excoriation..."</p> <p>During an observation of a skin check for Resident #20 on 01/11/12 at 11:30 A.M., The MDS Coordinator was observed to point to the sacral area and during an interview at that time, she indicated, "That's not a stage III." Upon request to facilitate a clearer observation, The MDS Coordinator separated the skin folds around the wound and indicated, "It's a stage III, I missed it, I didn't see it the other day...I just looked at it after his bath, I did not pull the buttocks apart..." At that</p>				

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	<p>time the MDS Coordinator measured the wound and indicated the measurements were "1.2 X 0.3 X slough".</p> <p>The Policy and Procedure for Management of Skin Integrity and Wound Prevention provided by the HFA on 1/11/12 at 4:00 P.M. indicated, "Purpose: The purpose is to be proactive in the prevention of skin breakdown for all resident while in our facility. However, if the resident is admitted with or develops a pressure ulcer, he or she will receive care and treatment to heal and further prevent development of pressure ulcers during their stay... Policy: The facility will practice appropriate pressure ulcer management and prevention for all resident...Procedure: 7. Possible intervention, ...a....repositioning q 2 [two] hours...When pressure ulcer is present...2. ...[in italics] Any new ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers..."</p> <p>The Policy and Procedure for Skin Care provided by the HFA on 01/11/12 at 4:00 P.M. indicated, "Purpose: ...Care of our patients to prevent pressure areas is a primary goal of the nursing staff...Prevention of pressure areas: 3. Change the patient's position frequently-at least every 2 [two] hours..."</p>				

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F0371 SS=F	<p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>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</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was prepared under sanitary conditions, in that, the handwashing sink in the kitchen for the staff to use did not provide warm water for 1 of 1 kitchens observed. This had the potential to affect 34 of 34 residents who consumed meals in the facility.</p> <p>Findings Include:</p> <p>During the initial kitchen tour on 01/09/12 at 9:30 A.M. the handwashing sink was utilized and noted to provide cold running water.</p> <p>During a kitchen observation on 01/11/12 at 8:40 A.M. the water tap of the handwashing sink was run for three</p>	F0371	<p>F 371</p> <ol style="list-style-type: none"> <li>The deficient practice was reported to the head of Maintenance. A copy of the regulation regarding the acceptable temperature range for the water in the sink was submitted to the maintenance director.</li> <li>Any staff member can be affected by the deficient practice which in turn can affect any resident's health. A copy of the regulation regarding the acceptable temperature range for the water in the handwashing sink was submitted to the maintenance director with a request to repair the problem and notify the Administrator of completion of the repair.</li> <li>The problem was assessed and it was found that there was a leakage of cold water into the water line serving the handwashing sink</li> </ol>	01/23/2012	

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	<p>minutes and the temperature measurement was 84 degrees Fahrenheit.</p> <p>During a kitchen observation on 01/11/12 at 10:45 A.M. Cook #1 was observed to wash her hands in the handwashing sink. Cook #1 was then observed to apply gloves and handle cooked chicken.</p> <p>During an interview on 01/11/12 at 8:45 A.M. the Certified Dietary Manager [CDM] indicated the kitchen has always had problems with getting the tap water warm enough because, it has a hot and cold water mixer.</p> <p>The policy and procedure provided by the Health Facility Administrator [HFA] for "Guidelines for Hand Hygiene Policy and Procedure" indicated, "facility would promote hand hygiene practices recommended by the Center for Disease Control." The Center for Disease Control web site indicated to rub hands with soap and warm water for 20 seconds.</p> <p>3.1-21(i)(2)</p>		<p>that was causing the water temperature to be diluted down to an unsuitable temperature. The problem was resolved and the temperature is within the acceptable range. Maintenance will check the temperature on a daily basis and record the temperature on a log sheet.</p> <p>4. The Maintenance staff will record the temperature in the handwashing sink daily. This will be monitored by the maintenance staff and a copy of the log sheet documenting the temperatures will be submitted to the Administrator on a monthly basis for a period of one year. Maintenance staff will report any variances in temperature to the maintenance director for immediate correction of the problem. The temperature logs will be reviewed monthly and the data reported at the quarterly QI meeting. (Attachment H)</p>		

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F0431 SS=D	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure multi-dose vials of medications, with the potential for abuse, were stored under double lock, in that, Ativan [a medication for anxiety] was observed to be stored in two of two medication rooms in unlocked refrigerators.</p>	F0431	<p>F 431</p> <p>1. Ativan was being kept in the Medication Room refrigerators behind one locked door. The surveyor noted that this was a Schedule II controlled drug and should be double locked. A lock was requested that day by the Administrator, from Maintenance,</p>	01/23/2012	

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	<p>Findings include:</p> <p>During an environmental tour on 01/11/12 at 9:30 A.M., the medication refrigerator in the medication room of the East Unit did not have a lock installed. At that time, the refrigerator contained 1 multi-dose bottle of Ativan 2 mg [milligram] per ml [milliliter].</p> <p>During an environmental tour on 01/11/12 at 9:35 A.M., the medication refrigerator in the medication room of the West Unit did not have a lock installed. At that time, the refrigerator contained 1 multi-dose bottle of Ativan 2 mg/ml .</p> <p>During an interview with RN #1 on 01/11/12 at 9:35 A.M. she indicated she did not know if controlled medications that require refrigeration should be double locked.</p> <p>During an interview with the DoN on 01/11/12 at 3:30 P.M. she indicated the facility stored the pill form of Ativan under double lock with the other controlled medications. The DoN also indicated she was aware Ativan should be stored under a double locked system.</p> <p>The policy and procedure for "Controlled Substance Inventory" provided by the</p>		<p>and the lock was installed the same day on the refrigerators in both the West and East Medication Rooms in the nursing stations.</p> <p>2. Any resident could have medication that is a Schedule II drug that is required to be held in a double locked area for safety purposes. The Administrator immediately requested that Maintenance obtain two padlock type locks that could be installed on the refrigerators in the Medication rooms in the nursing station areas. The work request was completed within 4 hours of the request and the refrigerators remain locked unless a nurse must access medication from that refrigerator. The addition of the padlocks on the refrigerators resulted in a double locked system.</p> <p>3. Nurses must check the temperature in these refrigerators daily and record it on a log sheet kept in the Medication Room at each nurse's station. The temperature log sheet has been revised to include a space in which the nurse can record the temperature on night shift and each shift can place a check mark to indicate the refrigerator was locked upon inspection. The new log sheet was presented during the inservice on 1/23/2012 to the nursing staff with an explanation for correct completion. (Attachment I)</p> <p>4. The Administrator currently</p>		

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	<p>Health Facility Administrator [HFA] on 01/11/12 at 3:30 p.m., indicated "schedule II through V drugs will be subjected to the same controls as the stock narcotics".</p> <p>The policy and procedure for "Medication Storage in the Facility" provided by the HFA on 01/11/12 at 5:00 p.m. indicated, "Schedule III-V medications and other medications subject to abuse are stored in a permanently affixed compartment separate from all other medications".</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l)</p>		<p>has a unit walk-through checklist and the lock verification review has been added to the checklist of items to monitor. The walk-through checklist will be done on weekdays and weekend compliance will be verified on Mondays by the Administrator. Any lack of documentation will be addressed with staff. The monitoring for locked refrigerators will be continued for a period of at least one year and results will be discussed at monthly inservices held with staff and at quarterly PI meetings. (Attachment H, J)</p>		

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F0441 SS=E	<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. Based on observation and record review, the facility failed to ensure policies and procedures for infection control were implemented for 3 of 3 sampled residents (#9, #17, #27) observed for meal service</p>	F0441	F 441 1. The proper standards for food handling were reviewed with all staff that participate in meal service for the residents so that food is properly	01/23/2012	

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	<p>and transfers in a sample of 10, in that staff did not wash hands prior to food handling and staff provided personal care without performing hand hygiene.</p> <p>Findings Include</p> <p>An observation was made on 1/9/12 at 12:05 p.m. of Certified Nursing Assistant #3 [CNA] assisting Resident #9 with the set up of lunch. CNA #3 removed a chicken breast from Resident #9's plate and placed it on the bun with ungloved hands. CNA #3 then proceeded to the tray cart and picked up Resident #17's tray and assisted her with set up of lunch. CNA #3 cut Resident #17's chicken sandwich in half, picked it up with her hands and handed half of the sandwich to Resident #17. CNA #3 was not observed to wash hands before or during the handling of more than one Resident's food.</p> <p>An observation was made on 1/11/12 at 8:20 a.m. of CNA #1 and CNA #2 transferring Resident # 27 from the bed to the recliner with a hoyer lift [a sling apparatus used with a mechanical hoyst, which lifts the resident up and down]. CNA #2 entered Resident # 27's room, washed hands, and put gloves on. CNA #1 came into the room did not wash hands or put gloves on, and proceeded with care.</p>		<p>handled during meal service.</p> <p>General infection control practices that are to be followed during resident care were also reviewed.</p> <p>2. Any resident could be affected by improper handling of food during meal service or disregarding infection control practices during care. Staff was re-educated as to proper procedure for infection control in regard to food handling and during resident care at an inservice on January 12, 2012 and again at an inservice on January 23, 2012.</p> <p>3. Proper infection control practices were reviewed with staff by the DON at two separate inservices held on January 12 and 23, 2012. The policy on "Feeding Residents" was reviewed and revised to include language regarding food handling precautions and sanitation during meal service. Infection Control practices were reviewed in this inservice as well. In addition, there were two additional dispensers of hand sanitizer and an additional glove dispenser installed in the dining room to provide better access for staff to sanitize hands or have gloves accessible as needed during meal service.</p> <p>4. Proper infection control practices were reviewed with staff by the DON at two separate inservices held on January 12 and 23, 2012. The policy on "Feeding Residents" was reviewed and revised</p>		

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	<p>CNA #1 and #2 turned Resident #27 to the left placing sling under the unclothed buttocks area, and then turned Resident #27 to right side and pulled sling underneath Resident #27 unclothed buttocks. CNA #1 and CNA #2 then rolled Resident # 27 on his back and pulled the sling up between legs and peri area. CNA #1 then unattached Resident #27's catheter bag from bed rail and placed it on the patients stomach area. CNA #1 and CNA #2 attached the sling to the lift and transferred Resident #27 to the chair. CNA #1 then dressed Resident #27 . CNA #2 placed the catheter bag on the side of the chair. CNA #1 left the room without washing her hands. CNA #2 removed gloves, used hand sanitizer and left Resident # 27's room.</p> <p>On 1/11/12 at 4:45 p.m. the Administrator provided a document dated 1/11/12 titled Gibson General Hospital Guidelines for Hand Hygiene Policy and Procedure, which indicated hands need to be decontaminated before having direct contact with patients. This document also indicated hands should be decontaminated after contact with patient's intact skin or contact with inanimate objects, and the facility would follow the Center For Disease Control's handwashing recommendations. The Center for Disease Control web site required hands</p>		<p>to include language regarding food handling precautions and sanitation during meal service. Infection Control practices, including the handwashing policy and the proper use of gloves, were reviewed in this inservice as well. In addition, there were two more dispensers of hand sanitizer installed in the dining room as well as a glove holder so there is better access for staff to sanitize hands or have gloves accessible as needed during meal service. (Attachment K)</p> <p>5. The DON will observe meal service randomly three times a week for compliance with proper food handling at meal service, making immediate corrections for compliance with policy if violations are observed. The DON will observe if handwashing takes place prior to meal service, that food is not touched during meal set-up and that hands are sanitized between residents. The DON will observe staff during care to observe compliance with proper infection control technique. The results of the monitoring will be reviewed with staff at each monthly inservice, with suggestions for improvement, for a period of one year. This monitor will be reported at the quarterly PI Meeting. (Attachments L, M)</p>		

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F0514 SS=D	<p>are washed with water and antibacterial soap for twenty seconds before and after patient care.</p> <p>3.1-18(b)(1)</p> <p>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 interview and record review, the facility failed to ensure clinical records were complete and accurately documented, for 2 of 2 residents reviewed for as needed medications, in the sample of 10, in that as needed medications were dispensed and the response was not accurately documented. (Resident #9 and #17)</p> <p>Findings include:</p> <p>1. During record review on 1/9/12 at</p>	F0514	<p>F514</p> <p>1. The records of the residents cited were reviewed. The PRN med sheet was audited for missing signatures/initials, lack of documentation regarding interventions and medication effectiveness.</p> <p>2. Any resident who receives PRN medications could be affected by the alleged deficient practice. All resident PRN Medication Administration Records (MAR) and flowsheets were reviewed for missing signature/initials, lack of</p>	01/23/2012	

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	<p>10:00 A.M., Resident # 9 had Lortab and Tylenol Extra Strength for pain ordered prn [as needed]. It was indicated on the Medication Record for December, 2011 and January , 2012, Resident #9 received the prn medications. The "Pain Management Flowsheet" for Resident #9 had 2 different pain intensity lists for pain assessment [the Wong-Baker Faces pain rating scale and the Pain Assessment in Advanced Dementia Scale] at the bottom of the record. According to the pain management flowsheet, Resident #9 did not receive follow-up assessment after being given pain medication according to the pain scale. Also no follow-up documentation for prn medications was indicated on the nurse's notes for Resident #9.</p> <p>No documentation was indicated for any of the interventions for Resident #9 except on 12/29/11 12/30/11, 1/8/12, and 1/9/12 at 9:55 P.M. The follow-up documentation did not follow policy nor were there any interventions indicated prior to giving Resident # 9 pain medication.</p> <p>Resident # 9 received the following:</p> <p>12/10/11 @ 8:00 A.M. - Lortab - no</p>		<p>documentation regarding interventions and medication effectiveness. Steps were taken to review and/or revise the current policy as well as the Pain Management flowsheet and the PRN flowsheet that covers documentation regarding interventions and medication effectiveness.</p> <p>3. The DON and Administrator reviewed the resident records and the flowsheets that document what steps are taken in the course of administering a PRN medication. Staff had completed the designated information but failed in some instances to document it in the correct column designated, making it difficult to ascertain what steps had been followed prior to administration and afterward to assess effectiveness.</p> <p>The policy and procedure was reviewed and revised to include administration of PRN medications. The flowsheets were also edited to include definite spaces to document the problem, alternative interventions attempted, and pain rating prior to administration and pain rating post administration. An "Example" is noted on each of the flowsheets to remind staff to document the required information in each column as designated. (Attachments N – P) Staff was inserviced regarding these changes on January 23, 2012.</p>		

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	<p>alternative interventions, no pain scale assessment</p> <p>for follow-up, and no documentation in the Nurse's Notes.</p> <p>12/10/11 @ 9:00 P.M. - Lortab - no alternative interventions, no pain scale assessment, no follow-up documentation in the Nurse's Notes</p> <p>12/11/11 @ 8:00 A.M. - Lortab - no alternative interventions, no pain scale follow-up assessment, no follow-up documentation in the Nurse's Notes</p> <p>12/11/11 @ 9:00 P.M. - Lortab - no alternative interventions, no pain scale follow-up assessment</p> <p>12/21/11 @ 5:45 P.M. - Lortab - no alternative interventions, no pain scale</p>		<p>4. PRN MARs, the Pain Flowsheets and PRN flowsheets are audited on a weekly basis by the DON for compliance and documentation completion. DON will immediately re-educate staff if non-compliance with policy is identified in audit process. Results of this audit will be compiled monthly and added to the quarterly Performance Improvement report. Results of the audit will be reviewed with staff at the monthly inservices given by the DON including discussions for improvements. The monitoring will be initiated for a period of one year. (Attachments Q – S)</p>		

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	<p>follow-up assessment, no documentation in the Nurse's Notes</p> <p>12/22/11 @ 7:00 A.M. - Lortab - no alternative interventions, no pain scale</p> <p>follow-up assessment, no follow-up documentation in the Nurse's Notes</p> <p>12/23/11 @ 4:00 P.M. - Lortab - no alternative interventions, no pain scale</p> <p>follow-up assessment, no follow-up documentation in the Nurse's Notes</p> <p>12/25/11 @ 5:00 P.M. - Lortab - no alternative interventions, no pain scale</p> <p>follow-up assessment, no follow-up documentation in the Nurse's Notes</p> <p>12/28/11 @ 6:00 P.M. - Lortab - no alternatives interventions, no pain scale</p> <p>follow-up assessment, no documentation</p>			

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	<p>in the Nurse's Notes</p> <p>12/29/11 @ 1:25 A.M. - Tylenol ES - no alternative interventions, no pain scale follow-up assessment, no follow-up documentation in the Nurse's</p> <p>12/29/11 @ 4:20 P.M. - Notes Lortab - no pain scale follow-up assessment</p> <p>12/30/11 @ 8:30 P.M. - Lortab - no pain scale follow-up assessment</p> <p>12/31/11 @ 1:15 A.M. - Tylenol - no alternative interventions, no pain scale follow-up assessment, no documentation in the Nurse's Notes</p> <p>1/2/12 @ 3:10 A.M. - Lortab - no alternative interventions, no pain scale follow-up assessment, no documentation in the Nurse's Notes</p>			

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	<p>1/2/12 @ 8:30 A.M. - Lortab - no alternative interventions, no pain scale follow-up assessment, no documentation in the Nurse's Notes</p> <p>1/2/12 @ 4:00 P.M. - Tylenol - no alternative interventions, no pain scale follow-up assessment, no documentation in the Nurse's Notes</p> <p>1/3/12 @ 10:00 A.M. - Lortab - no alternative intervention, no pain scale follow-up</p> <p>1/4/12 @ 1:10 A.M. - Lortab - no alternative intervention, no pain scale follow-up assessment</p> <p>1/7/12 @ 8:00 P.M. - Lortab - no alternative intervention, no pain assessment prior to or after receiving</p>			

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	<p>medication</p> <p>1/8/12 @ 11:15 P.M. - Lortab - No pain scale follow-up assessment</p> <p>1/9/12 @ 5:30 P.M. = Lortab - no alternative intervention, no pain scale follow-up assessment, no documentation in the Nurse's Notes</p> <p>1/9/12 @ 9:35 P.M. - Tylenol ES - no pain scale follow-up assessment, no documentation in the Nurse's Notes</p> <p>1/12/12 @ 12:45 A.M. Lortab - No alternative interventions, no pain scale follow-up assessment, no documentation in the Nurse's Notes</p> <p>According to the care plan for pain, dated 1/11/12, Resident #9 should have her pain level assessed every shift; reposition in bed and chair to see if feels better; alternate interventions e.g. back rubs,</p>			

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	<p>1:1,etc [and so forth]... No documentation as outlined in the record which indicated for pain medication follow-up given on 1/12/12.</p> <p>2. During record review on 1/10/12 at 9:00 A.M., the Medication Record for December, 2011, and January, 2012, indicated Resident # 17 received prn pain medication [Lortab] for pain and prn medication [Lomotil] for loose stool. The "Pain Management Flowsheet" indicated 2 different pain assessment scales for pain assessment [Wong-Baker Faces scale and Pain Assessment Scale for Advanced Dementia Scale.] According to the pain management flowsheet, Resident #17 did not receive a follow-up assessment. Also, no follow-up documentation for the Lomotil prn medications was indicated on the nurse's notes for Resident #17.</p> <p>Resident #17 received the following:</p> <p>12/11/11 @ 8:30 A.M. - Lortab - no pain scale follow-up assessment, no documentation in the Nurse's Notes 12/13/11 - no legible time - Mylanta - no follow-up assessment, no documentation in the Nurse's Notes 12/16/11 @ 4:00 P.M. - Lortab - no pain scale follow-up assessment, no documentation in the Nurse's Notes 12/18/11 - no legible time - Lortab - no</p>				

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	<p>pain scale follow-up assessment, no documentation in the Nurse;s Notes 12/19/11 @ 1:45 A.M. - Lortab - no pain scale follow-up assessment, no documentation in the Nurse's Notes 12/25/11 @ 8:00 P.M. - Lomotil - no documentation on the Medication Administration Record 1/11/12 @ 9:00 A.M. - Lortab - no alternative intervention, no pain scale follow-up assessment, no documentation in the Nurse's Notes</p> <p>The Care Plan Form, for comfort measures R/T decline in health/Hospice, obtained on 12/21/11, for Resident #17, the following comfort measures should be provided. Resident #17 is to be given pain medications as ordered and their response monitored, turn and reposition with pillows and off load feet, back rubs, soft music, and visits 1:1 provided. No documentation for the interventions was indicated.</p> <p>During the interview with the DoN on 1/12/12 at 5:30 P.M., she indicated that you would assess prn medications using a numeric pain scale prior to and after giving prn medication and that alternative interventions should be used prior to administering prn medications. Also, the DoN indicated that follow-up assessment</p>			

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	<p>of prn medications should be documented.</p> <p>During an interview with the Administrator on 1/12/12 at 9:15 A.M., she indicated documentation for prn medications was found on the Pain Medication Flowsheet. The Administrator indicated the follow-up for the prn pain medication is indicated by "effective, the pain assessment scale, or helped." Upon query of the Administrator regarding follow-up using the pain scales, she indicated that staff should probably be using the scale that is listed at the bottom of the Pain Medication Flowsheet and for follow-up of non-pain prn medications should be documented in the nurse's notes.</p> <p>According to the policy, "Pain Assessment- SNF," obtained on 1/12/12 at 8:10 A.M., the purpose indicates that a"standardized method for assessing the extent or amount of pain will be utilized by all departments of [name of the facility]. Because pain is very subjective and does not illicit the same response from patients being affected by it, the hospital approved pain scale will be utilized in an effort to standardize practitioner to practitioner the evaluation of the discomfort and the response to the intervention." The procedure indicates that pain will be assessed at the beginning</p>			

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	<p>of each shift or procedure and regularly throughout the shift or procedure as indicated, comfort measures will be taken, i.e. [for example] repositioning, providing support with pillows, engaging in conversation with the patient, etc.[and so forth]..., response to interventions will be assessed at appropriate intervals, and accurate accounts of assessments made, actions taken, interventions made and follow-up evaluations of those interventions will be documented in the patient's medical record." Upon query of the Administrator on 1/12/12 at 8:10 A.M., she indicated the nursing staff was to follow the policy titled "Pain Assessment - SNF."</p> <p>3.1-50(a)(1)</p>			