

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00191286 and IN00193960. This visit resulted in an Extended Survey - Immediate Jeopardy - Substandard Quality of Care.</p> <p>Complaint #IN00191286- Unsubstantiated due to lack of evidence.</p> <p>Complaint #IN00193960 - Substantiated/ Federal/State deficiencies related to the allegations are cited at F225, F226, F280, F282, F309, F312, F315 and F323.</p> <p>Survey dates: March 7, 8, 9, 10 and 11, 2016 Extended survey dates: March 12, 13, 14, 15 and 16, 2016.</p> <p>Facility number: 000475 Provider number: 155406 AIM number: 100290540</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 02</p>	F 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by the state and federal law. Hickory Creek at Peru desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective 4/15/16.</p>	
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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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F 0225 SS=F Bldg. 00	<p>Medicaid: 25 Other: 06 Total: 33</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on March 27, 2016</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to</p>				

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	<p>the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure 2 of 4 allegations of abuse was investigated and reported timely. This deficient practice had the potential to affect 33 of 33 residents.</p> <p>Finding includes:</p> <p>Based on confidential information, residents and staff were interviewed regarding abuse, including an allegation of sexual abuse involving Resident "G" and two Certified Nursing Assistants (CNA's).</p> <p>During an interview, on 03/09/16 at 8:59 A.M., LPN (Licensed Practical Nurse) #50 indicated she had overheard staff conversing about Resident "G"</p>	F 0225	<p>It is the policy of this facility to ensure that occurrences of verbal or physical abuse, including resident-to-resident situations, are reported immediately to the Administrator, investigated, and reported timely to the state agency. 1. <u>What corrective action will be done by the facility?</u> The Administrator did suspend the staff involved in the allegation of abuse when notified during survey of the occurrence once again. She also notified the state agency of the occurrence and followed through with a 5-day follow up as per state guidelines. Since that time, the Administrator has been replaced. Resident G has had his care plan reviewed and updated to be reflective of his current behaviors and interventions. The current Administrator, DON, and Nurse Consultant will re-train all staff</p>	04/15/2016	

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	<p>inappropriately touching CNA # 51. The nurse indicated she reported the incident to the Administrator and Director of Nursing to make sure they were aware of the incident. She indicated she had reported the allegation approximately a month ago, as soon as she overheard other staff talking about the incident.</p> <p>During an interview on 03/09/16 at 1:45 P.M., the Activity Director indicated she was aware of "hearsay" regarding Resident "G" and "second shift CNA's." She indicated she had heard Resident "G" had his hands down the pants of a CNA, between her pants and underwear, and was "rubbing" her. She indicated she had heard about the incident about a month ago and she would have reported it to the Administrator but she knew for a fact another staff member, who also heard about the incident at the same time, had immediately reported the allegation to the Administrator. She indicated she had never witnessed Resident "G" touching staff inappropriately herself.</p> <p>During an interview, on 03/10/16 at 2:16 P.M., CNA #52 indicated she had reported an incident she considered sexually inappropriate between Resident "G" and CNA #53 to the Administrator about a month ago. CNA #52 indicated she had entered Resident "G's" room to</p>		<p>regarding the facility's Standards of Conduct, which outlines the expectation that an allegation of any type of abuse or neglect, including sexual abuse, must be reported immediately to the Administrator. As part of her orientation to the facility, the interim Administrator has been oriented to the facility policy regarding the prompt reporting of allegations of abuse or neglect to the state agency, and the requirement for starting an investigation immediately upon receiving an allegation of abuse or neglect. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice. The DON will review the 24 hour report, incident reports, and pertinent progress notes at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed including those that demonstrate issues with resident behaviors that are</p>		

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	<p>assist CNA #53 with resident care and she witnessed Resident "G" with his hands down the pants of CNA #53. She indicated CNA #53 was allowing Resident "G" to have his hand down her pants. She indicated she interrupted the activity and Resident "G" did remove his hand. CNA #53 then tried to make up an excuse to CNA #52 regarding why Resident "G's" hand was down inside her outside pants. CNA #52 indicated she felt the incident was not accidental and she reported the incident to the Administrator the same morning when the day shift arrived in the building. CNA #52 indicated she was not asked for further information regarding the incident she had witnessed and reported until 03/09/16.</p> <p>An interview was conducted on 03/14/16 at 10:45 A.M., with the Administrator regarding the facility's Abuse prohibition policies and procedures. The Administrator indicated she had been informed of the concern regarding Resident "G" and CNA #53 on 02/02/16 by CNA #52. She indicated she had "looked into it" but had not formally investigated the concern as an allegation of possible abuse because she had initially been told the resident's hand was on the CNAs "butt." She indicated when it had again been brought to her attention</p>		<p>affecting other residents. Recommendations made by the team will be followed up by the designated team member(s). Any changes to the behavior logand care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as needed and will indicate a change in interventions or behavior plan on the 24 hour report form to make sure that communication is extended to other shifts. 3.. <u>What measures will be put into place to ensure this practice does not recur?</u> In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director will monitor residents' environment and any indication of discomfort or unease with other residents or staff as part of their frequent rounds that occur during each tour of duty. Any concern expressed regarding any resident will be documented on a resident concern form and will be brought to the attention of the Administrator immediately, if she is not the one who has received the concern firsthand. Once the staff and the Administrator have made sure that safety is assured for all residents involved,the Administrator will bring the</p>				

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	<p>during the survey process, she had initiated an investigation and had reported the allegation to the Indiana State Department of Health on March 9, 2016 at 5:15 P.M.</p> <p>This Federal tag relates to Complaint IN00193960.</p> <p>3.1-28(c) 3.1-28(d)</p>		<p>interdisciplinary team and related documentation together to discuss the concern expressed by the resident. The Administrator will also notify the Indiana State Board of Health if the concern meets the guidelines as a "reportable incident" and will begin an investigation. She will also notify ISDH of the results of her investigation into the incident as required by Indiana guidelines. The attending physician and family/legal representative will be notified of the occurrence – if directed by the attending physician, the psychologist will also be notified. The facility will follow through on the physician's recommendations and will document the results. At least twice a month, the Nurse Consultant will review any instances of physical or verbal abuse that have occurred and been reported to the state agency since her prior visit to make sure that reporting and follow up have occurred as required. If she identifies any issues, she will review them with the Administrator and other involved staff and will re-train them in regards to the facility policy and the state/federal regulations. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put in place?</u> The Administrator and Social Services Director will report any</p>		

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F 0226 SS=F Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their policy and procedure for abuse was implemented related to investigation and reporting 2 of 4 allegations of abuse. This deficient practice had the potential to affect 33 of 33 residents.</p> <p>Finding includes:</p>	F 0226	<p>occurrences of resident abuse and other ongoing behaviors, along with the results of specific interventions designed to prevent the abuse situation, to the monthly QA&A Committee meeting for further review and recommendations. The Administrator will also report any recommendations made by the Nurse Consultant's audits of abuse incidents and subsequent reports. Recommendations will be followed up by the designated person who will report the results of those recommendations at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 4/15/16</p> <p>It is the policy of this facility to report allegations of abuse to the Administrator immediately so that she can report the allegations to the Indiana Department of Health as indicated by state policy in order to begin a thorough investigation into the incident.</p> <p>1. <u>What corrective action will be done by the facility?</u> The prior Administrator has been replaced since the time of the survey. The</p>	04/15/2016	

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	<p>Based on confidential information, residents and staff were interviewed regarding abuse, including an allegation of sexual abuse involving Resident "G" and two Certified Nursing Assistants (CNA's).</p> <p>During an interview, on 03/09/16 at 8:59 A.M., LPN (Licensed Practical Nurse) #50 indicated she had overheard staff conversing about Resident "G" inappropriately touching CNA # 51. The nurse indicated she reported the incident to the Administrator and Director of Nursing to make sure they were aware of the incident. She indicated she had reported the allegation approximately a month ago, as soon as she overheard other staff talking about the incident.</p> <p>During an interview on 03/09/16 at 1:45 P.M., the Activity Director indicated she was aware of "hearsay" regarding Resident "G" and "second shift CNA's." She indicated she had heard Resident "G" had his hands down the pants of a CNA, between her pants and underwear, and was "rubbing" her. She indicated she had heard about the incident about a month ago and she would have reported it to the Administrator but she knew for a fact another staff member, who also heard about the incident at the same time, had immediately reported the allegation to the</p>		<p>current Administrator, DON, and Nurse Consultant will re-train all staff regarding the facility's Standards of Conduct, which outlines the expectation that an allegation of any type of abuse or neglect, including sexual abuse, must be reported immediately to the Administrator. As part of her orientation to the facility, the interim Administrator has been oriented to the facility policy regarding the prompt reporting of allegations of abuse or neglect to the state agency, and the requirement for starting an investigation immediately upon receiving an allegation of abuse or neglect. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice, but there have been no further instances of lack of reporting allegations of abuse to the Administrator or Indiana Department of Health since this survey. In the future, however, if the Administrator becomes aware of any allegation of abuse that has not been reported to her as per facility policy, she will make sure that the resident is safe and well and will notify the physician, family, and Indiana Department of Health. She will also initiate an investigation at that same time. As part of her investigation she will identify any staff member who</p>		

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	<p>Administrator. She indicated she had never witnessed Resident "G" touching staff inappropriately herself.</p> <p>During an interview, on 03/10/16 at 2:16 P.M., CNA #52 indicated she had reported an incident she considered sexually inappropriate between Resident "G" and CNA #53 to the Administrator about a month ago. CNA #52 indicated she had entered Resident "G's" room to assist CNA #53 with resident care and she witnessed Resident "G" with his hands down the pants of CNA #53. She indicated CNA #53 was allowing Resident "G" to have his hand down her pants. She indicated she interrupted the activity and Resident "G" did remove his hand. CNA #53 then tried to make up an excuse to CNA #52 regarding why Resident "G's" hand was down inside her outside pants. CNA #52 indicated she felt the incident was not accidental and she reported the incident to the Administrator the same morning when the day shift arrived in the building. CNA #52 indicated she was not asked for further information regarding the incident she had witnessed and reported until 03/09/16.</p> <p>An interview was conducted on 03/14/16 at 10:45 A.M., with the Administrator regarding the facility's Abuse prohibition</p>		<p>was aware of or involved in the allegation of abuse and did not report it on a timely basis, as per facility policy. Once that is confirmed through the investigatory process, she will follow up with progressive disciplinary action for the noncompliance. Any staff who was involved and is still employed, will receive re-education on resident rights and the facility abuse reporting policy before that same staff can resume work. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The facility utilizes a guardian angel program manned by the department managers at least 5 days a week. Each one talks with his/her assigned residents and families to ascertain their satisfaction with the services they are receiving. The results of those visits are brought to the morning management meeting that occurs at least 5 days a week for further review and follow up to any outstanding issues. However, if an allegation of abuse is discovered as part of these visits, the manager will notify the Administrator immediately who will follow the process as laid out in question#2. In addition, any written resident or family grievances or concerns will be reviewed by the Administrator and the Interdisciplinary Team (IDT) members when received by the facility. If alleged abuse is</p>				

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F 0241 SS=E Bldg. 00	<p>policies and procedures. The Administrator indicated she had been informed of the concern regarding Resident "G" and CNA #53 on 02/02/16 by CNA #52. She indicated she had "looked into it" but had not formally investigated the concern as an allegation of possible abuse because she had initially been told the resident's hand was on the CNAs "butt." She indicated when it had again been brought to her attention during the survey process, she had initiated an investigation and had reported the allegation to the Indiana State Department of Health on March 9, 2016 at 5:15 P.M.</p> <p>This Federal tag relates to Complaint IN00193960.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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, record review, and</p>	F 0241	<p>identified, the Administrator will respond and follow the process as outlined in question #2. 1. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put in place?</u></p> <p>The Administrator and/or Social Service Designee will bring any allegations of abuse that have been received, along with the investigation details and results of the investigation to the monthly QAA Committee meeting for review and further recommendations for action identified. If recommendations for further improvement are received, the Administrator or involved manager will follow up on the recommendations and will report their status at the next scheduled QAA Committee meeting. This process will continue on an ongoing basis.</p> <p>Date of Compliance: 4/15/16</p> <p>It is the policy of this facility to promote care for residents in a</p>	04/15/2016			

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	<p>interviews, the facility failed to ensure the dignity of resident's during the dining observation by identifying their preference for wearing a clothing protector during 2 of 2 dining observations. (Resident "G", #2 #6, #17, #24, #25, #31 and "F") In addition, the facility failed to ensure dignity during the dining service regarding 2 resident's were observed eating food with their fingers without the use of assuasive devices or cueing from staff. (Resident #10 and #19). Staff was observed placing a tray in front of a resident who was asleep, the staff did not attempt to talk to him or wake him up for his meal and then walked away. (Resident #27) This deficiency had the potential to affect 11 of 33 resident's who eat their meals in 2 of 2 dining rooms.</p> <p>The facility also failed to maintain visual privacy for 2 of 33 resident's who reside in the facility. (Resident # 32 and #47)</p> <p>Findings include:</p> <p>1. On 3/7/16 at 12:25 P.M., CNA (Certified Nursing Assistant) #21 was observed in the assisted dining room placing cloth clothing protectors on Resident "G", #2, #6, #17, #24, #25, #31 and "F" without asking the resident's first.</p> <p>On 3/7/16 at 12:29 P.M., in the</p>		<p>manner and in an environment that maintains or enhances each resident's dignity and respect, including when receiving assistance with meals, keeping their body covered, and covering Foley catheter drainage bags when in public locations. 1. <u>What corrective action will be done by the facility?</u> The DON and Nurse Consultant will in-service staff regarding the need to allow residents' choice regarding whether or not they wish to wear clothing protectors. In addition staff will also be in-serviced on the proper procedure to follow when assisting a resident to eat; for example, remaining with the resident until the meal is finished as indicated by the resident's condition at that time, making sure that assistive devices are available and being used for the resident, encouraging and cueing the resident to remain awake to eat, and, if needed, to assist the resident during times that he is not able to feed himself. They will also be in-serviced on the need to make sure that residents' body parts and appliances are covered whenever they are in a position to be seen by others, including coverings for Foley catheter drainage bags. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by these practices;</p>				

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	<p>independent dining room, Resident #10 was observed attempting to eat her meatloaf and mashed potatoes with her fingers. No assistive devices were observed and no staff were present to cue or assist the resident. The resident had meatloaf and mashed potatoes on her fingers and on her lap.</p> <p>On 3/9/16 at 12:10 P.M., CNA #22 was observed in the assisted dining room placing cloth clothing protectors on Resident "G", #2, #6, #17, #24, #25, #31 and "F" without asking the resident's first.</p> <p>During an interview, on 3/13/16 at 12:45 P.M., the Director of Nursing indicated when the staff bring the resident's to the dining room for their meal they ask the resident if they would like to have a clothing protector and if the resident says yes the staff place the protector on the resident. She further indicated staff always ask the resident first.</p> <p>2. On 3/14/16 at 2:06 P.M., Resident #32 in Room 18 was observed sitting in his wheelchair in his room. The resident was visibly seen while walking by in the hallway. The resident was asleep and his t-shirt was pulled up exposing his bare abdomen and his colostomy bag.</p> <p>On 3/14/16 at 2:41 P.M., Resident #32</p>		<p>however, no other instances have been noted since survey. The DON and Nurse Consultant re-trained the staff during the survey when they realized that improper procedures were being followed regarding the placement of clothing protectors, the techniques being used while assisting residents to eat, and the lack of covering of residents and their appliances in public places. However, if any issue is noted during meal service, the interdisciplinary team manager or nurse assigned to monitor and assist with the meal will stop the inappropriate practice immediately, make sure that the resident's needs are attended to at that time, and will re-instruct the staff involved on the facility policy. If any IDT member observes that a resident or his/her appliances are not covered appropriately, he will address the issue with the staff present at that time. Once the resident is cared for, the IDT member will notify the DON or Administrator (if they are not already aware of the issue) who will re-train the staff involved in the facility policy and procedure. Progressive counseling will also be rendered for continued non-compliance. 1. <u>What measures will be put into place to ensure this practice does not recur?</u> One of the interdisciplinary team members is assigned to monitor each meal to</p>	

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	<p>was still visibly seen from the hallway sitting in his wheelchair with his t-shirt pulled up exposing his bare abdomen and his colostomy bag.</p> <p>On 3/14/16 at 3:00 P.M., CNA #23 entered Resident #32's room and indicated she knew that the resident's abdomen should be covered and not exposed.</p> <p>3. On 3/7/16 at 12:00 P.M., Resident #19 was observed using her fingers to eat with. She was also observed taking her fingers into a butter cup and eating the butter off her fingers. The DON was observed standing in hallway facing the main dining room area. The DON kept looking toward the kitchen. There was no interaction with residents and staff in main dining area observed at this time.</p> <p>4. On 3/10/16 at 12:06 P.M., Resident #27 was observed entering the main dining area, being propelled by a staff member. The resident was placed in front of a table and the staff member walked out of the dining area. The resident's eyes were closed. The Social Service Director was observed placing the resident's lunch in front of him and walking away. The Social Service Director did not attempt to awaken the resident or ask him what he wanted to</p>		<p>assist with the meal service, but also to monitor staff performance during the meal. As indicated in question #2, if any concern or issue is identified the manager or nurse will address the staff immediately and re-train them in the acceptable procedure to follow. The meal manager will use a QA tool, "Meal Service" to document what he/she has observed, as well as any action taken to correct any concerns or issues that were observed. The meal manager will bring the completed QA tool to the next scheduled interdisciplinary morning manager meeting to review the results of his/her monitoring activities, as well as any action taken. 2. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or designee will bring the results of the Meal Service audits and the DON will bring the results of the audit to the monthly QA&A Committee meeting for further review and recommendations for process improvement. This will continue for the next 3 months – once 100% compliance has been reached, the Committee members may decide to stop the written audits. Even when the written audits are stopped, the process of monitoring the meals and reporting meal service issues will continue on an ongoing basis. Date of Compliance: 4/15/16</p>				

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	<p>drink. Several staff members walked by the resident but did not encourage him to wake up or bring him fluids until LPN #3 was observed trying to awaken the resident, she asked for grape juice to be brought to the resident and LPN #3 attempted to have the Resident drink some juice. LPN #3 asked the resident to open his eyes and take a drink, and the resident responded and took several sips of the juice. LPN #3 then fed the resident a few bits of potatoes and the resident opened his eyes and completed his meal.</p> <p>On 3/11/16 at 12:10 P.M., the Director of Nursing provided a policy titled "Quality of Life", dated October 2004, and indicated the policy was the one currently used by the facility. The policy indicated "...Employees of this facility will base their interactions with resident and others in the knowledge that each customer is a unique individual whose dignity is to be maintained and enhanced with each staff interaction... Promoting dignity and independence during the dining Promoting dignity and independence during the dining experience by *offering choice *assisting with food preparation so the highest degree of self-performance can be achieved...*reduce noise *providing an atmosphere conducive to pleasant dining...*pulling privacy curtain and window curtains...*performing all</p>			

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	<p>treatments in a private area...."</p> <p>5. During the initial tour, on 3/7/16 at 9:50 A.M., Resident #47's indwelling Foley catheter bag was observed from the hallway. The Foley catheter bag was not in a dignity bag and was observed on the floor, slightly under the resident's bed.</p> <p>On 3/8/16 at 9:44 A.M., Resident #47's indwelling Foley catheter bag was observed on the floor and was not covered with a dignity bag.</p> <p>On 3/9/16 at 7:28 A.M., Resident #47's indwelling Foley catheter bag was observed hanging on the bed frame, in front of the dignity bag.</p> <p>On 3/9/16 at 2:29 P.M., Resident #47 was observed from the hallway to have a brief on and no sheet covering his brief or legs.</p> <p>On 3/11/16 at 12:10 P.M., the Director of Nursing (DON) provided a current policy titled "Catheter Care - General Information," dated June 2004. The policy did not indicate the Foley catheter was to be placed in a dignity bag.</p> <p>3.1-3(t)</p>						

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F 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to provide shower assistance according to resident preferences. This deficient practice had the ability to affect 2 of 3 residents reviewed for choices. (Residents #11 and "I")</p> <p>Findings include:</p> <p>1. During an interview on 3/8/2016 at 9:08 A.M., Resident #11 indicated that he does not get to choose how many times a week he takes a shower. He further indicated that he prefers to take a shower, as this is what he did at home.</p> <p>A clinical record review was completed on 3/9/2016 at 12:25 P.M., for Resident #11. The clinical record indicated Resident #11 was admitted on 2/8/2016. The diagnoses included, but were not limited to: kidney failure, aphasia,</p>	F 0242	<p>It is the policy and standard of practice that this facility ensures resident's preferences for showering. 1. <u>What corrective action will be done by the facility?</u> Resident #11 and Resident "I" were their preference of how many times they preferred a shower. Preferences were documented on the facility . Bathing preferences were also added to the CNA Assignment sheet. All nursing staff will be in-serviced by the DON and Nurse Consultant regarding the residents' right to and that each one's preference will be listed on the bathing/shower list, CNA assignment sheets, and the residents' care plans. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected. Each resident's preference for bathing frequency has been reviewed with them or</p>	04/15/2016

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	<p>dysphasia, muscle weakness, difficulty in walking, arthropathy, arteriosclerotic heart disease of native coronary artery without angina pectoris, secondary hypertension and peripheral vascular disease.</p> <p>A care plan, dated d2/25/2016, indicated "...My skin condition will be monitored at least twice a week by the CNA (Certified Nursing Assistant) during my shower and weekly by the charge nurse...."</p> <p>A shower schedule, dated 1/28/2016, indicated Resident #11 was to be assisted with a shower every Monday and Thursday.</p> <p>A CNA documentation report indicated Resident #11 had not received a shower from March 2 thru March 9.</p> <p>2. During an interview on 3/7/2016 at 11:41 A.M., Resident "I" indicated that she would like to have more showers than she is currently receiving.</p> <p>A clinical record review was conducted on 3/9/2016 at 8:53 A.M., for Resident "I". The clinical record indicated Resident #38 was admitted on 10/27/2015. The diagnoses included, but were not limited to: chronic</p>		<p>their responsible party. Each CNA assignment sheet and care plan has been updated, if needed, to accurately reflect each resident's choice. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> Upon admission, residents will be interviewed by the Social Service Director using the Admission Questionnaire. She will also ask for the resident's preference for bathing frequency and add that onto the questionnaire itself. Results of the interview will be added to the CNA Assignment Sheet and Care Plans will be initiated for guidance of providing care by staff members for each resident respectively. During scheduled care plan conferences each resident's preferences for bathing frequency will be checked at that time. If his/her choice remains the same, nothing more will be done; however, if it has changed, the CNA Assignment Sheets and the resident's care plan will be updated accordingly.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Director of Nursing or her designee will perform audits of random shower preferences, 5x a week for 4 weeks, 3x a week for 3 weeks and at least weekly thereafter. Audits will be presented weekly in Standards of Care meeting for review. Monthly updates will be presented to the</p>		

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	<p>obstructive pulmonary disease, atherosclerosis of autologous artery coronary artery bypass graft with other forms of angina pectoris, major depressive disorder recurrent mild, anxiety disorder and muscle weakness.</p> <p>A care plan, dated 11/10/2015, indicated "...I am to receive assistance to shower daily...."</p> <p>A CNA documentation report indicated Resident "I" did not receive a shower from February 1 thru February 15.</p> <p>A shower schedule, dated 1/28/2016, indicated Resident "I" is scheduled to receive a shower every Tuesday and Friday.</p> <p>During an interview on 3/9/2016 at 10:02 A.M., the Administrator indicated Resident "I's" care plan did not reflect the residents shower preference.</p> <p>On 3/14/16 at 11:36 A.M., the corporate nurse provided a policy titled "Bath - Bed, Partial, Shower, Tub," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated "...All residents who are bed-bound should receive a completed bed bath at least twice a week, with a partial bath on the days that a complete</p>		<p>Quality Committee for the next 3 months. After two consecutive quarters of compliance, audits may be modified by the Quality Assurance Committee. Completion Date: 4/15/16</p>		

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F 0272 SS=E Bldg. 00	<p>bath is not given. Other residents who are out of bed should receive at least two (2) showers or tub baths per week, with partial baths between showers...."</p> <p>3.1-3(u)(1)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;</p>			

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	<p>Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interviews, the facility failed to ensure timely, accurate assessments were completed for nutrition (Resident "H"), pressure ulcers (Resident #11 and 47), a contracture (Resident #9), bladder incontinence (Resident #31 and "I"), nonpressure skin impairment (Resident "B" and #32), post dialysis needs (Resident #11), behavior assessment for inappropriate touching (Resident "G") and an indwelling urinary catheter (Resident #47). This affected 11 of 15 residents reviewed for assessments.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #7 was reviewed on 03/09/2016 8:57:05 AM. Resident "H" was admitted to the facility 08/27/12 with diagnoses, including but not limited to: heart failure, cerebrovascular disease, hemiplegia, major depressive disorder, hypothyroidism, hypertension, metabolic disorder, osteoporosis, hyperlipidemia, seizures, and pseudobulbar affect.</p>	F 0272	<p>It is the policy of this facility to ensure that timely, accurate assessments are completed for all residents regarding their nutrition, pressure ulcers, contracture, bladder incontinence, post dialysis needs, indwelling catheter use, and inappropriate behaviors. 1. <u>What corrective action will be done by the facility?</u> The facility now has a new electronic scale to make sure that residents' weights, including Resident H, are accurate. Resident H has been weighed with the new scale on 4/6/16 with a resulting weight of 190 pounds which is the same weight that she had in March. She was reviewed by the IDT and dietitian in the Nutrition-At-Risk meeting and is on weekly weights at this time. Her care plan is current and no further interventions have been suggested by the RD at this time. The staff has been trained in the use of the electronic scale and the need for accuracy of weights. Resident #47 is no longer at the facility. Resident #11's open area to his left arm is healed. Nursing staff will be in-serviced on the facility policy for documentation of</p>	04/15/2016			

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	<p>The resident's weight on 07/01/15 was 210 pounds. Her weight, documented on 01/21/16 was 201 pounds. Her weight on 02/09/16 was down to 191 pounds.</p> <p>During an interview, on 03/09/16 at 11:00 A.M., with the FSS (Food Service Supervisor), she indicated Resident "H's" last dietary progress note was completed on 02/09/16. The note indicated the resident's weight was documented as 204 pounds and the documentation indicated the resident had no significant weight loss. The FSS indicated she had had issues with weight documentation in the past. She indicated Resident "H" had not been weighed yet for March 2016.</p> <p>During an interview with the FSS, on 03/09/16 at 2:45 P.M. she indicated Resident "H" had been weighed on 03/09/16 and her weight was 190 pounds as she stood. The FSS indicated the weight did reflect a 9.5 percent weight loss in the past 6 months and confirmed a significant weight loss from January to February 2016. She indicated she thought perhaps there had been a discrepancy between weights due to the manner in which she had been weighed but she was not certain. She indicated the resident had good intakes and snacked in her room.</p>		<p>skin assessments upon admission and then weekly for all residents; notifying the physician and obtaining orders for treatment of the identified areas; and documentation of administration of treatment orders on the treatment administration record (TAR);inclusion of the use of Foley catheters on the resident's care plan; the need for physician orders for the use, care, and treatment of a Foley catheter The area noted on Resident B's forearm has healed. In addition to the information for staff in-service above, the staff will also be trained on documentation of conversations with providers who work with the residents outside of the facility; use of the bruise investigation form for documentation of any identified bruises or discolorations observed on residents. Resident #31 will have a new bowel and bladder assessment done by 4/15/16. Resident I will have a bladder assessment redone by 4/15/16. Based on the results of that assessment, their care plans will be updated to accurately reflect the status of the bladder and/or bowel,including an individualized plan to check, toilet, and change the resident on a frequent basis in order to keep skin as clean and dry as possible. Nursing staff will be in-serviced by the DON and Nurse Consultant on completion and timeliness of bowel and bladder</p>		

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	<p>2. . On 3/9/16 a 9:22 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was admitted on 2/26/16 and re-admission on 3/4/16. The resident's diagnoses included but was not limited to: adult failure to thrive, chronic obstructive pulmonary disease, insulin dependent diabetic-uncontrolled, chronic embolism/thrombosis of deep veins of lower extremity (bilateral), viral hepatitis and congestive heart failure.</p> <p>A hospital History & Physical, dated 2/26/16, indicated the resident had a decubitus ulcer on his buttock, multiple abrasion on lower extremities, some areas open/weeping others scabbed and multiple abrasions on forearms as well.</p> <p>A form titled " Licensed Nurse Weekly Skin Assessment," dated 2/26/16, indicated the resident was admitted with a pressure ulcer on his coccyx, a bruise on his left elbow and multiple scrapes on his lower extremities. There were no measurements or staging of the coccyx pressure ulcer or measurements of the resident's other skin abnormalities. The resident's Braden score was 16 which indicated the resident was at high risk for skin breakdown.</p> <p>A physician's order, dated 3/1/16,</p>		<p>assessments, as well as inclusion on the residents' plans of care. Resident #11 is no longer at the facility and there are no other residents requiring dialysis at this time. However, the nurses will be in-serviced in the use of the post-dialysis documentation form, which is to be used to assess a resident's status upon the return from a dialysis visit. This requirement will be reviewed with them again when a dialysis resident is admitted once to the facility once again. Additionally, the DON and Administrator have been in-serviced by the Nurse Consultant regarding what information will be needed from dialysis providers on a routine basis before confirming them as providers for facility residents in the future. Resident #9's care plan has been updated to reflect her consistent choice not to wear a splint on her right arm to have ROM to her upper body. There will be a modification done to the 3/9/16 MDS to accurately reflect the fact that she is unable to move her right arm. Nursing staff will be in-serviced on the need for splints and ROM for residents who have contractures or are otherwise unable to move one of their extremities. They will also be in-serviced on informing the DON or charge nurse if a resident refuses the use of these other devices/modalities. The DON will talk with the family of Resident G</p>				

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	<p>indicated to apply mepilex dressing (a wound dressing) on the resident's coccyx daily and as needed. There were no orders for the treatment of the Resident's Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) coccyx pressure ulcer prior to 3/1/16.</p> <p>A progress note, dated 3/1/16, indicated the resident had a stage II pressure ulcer on his coccyx. The wound measured 0.6 x 1.0 centimeters (cm).</p> <p>A Nursing Admission Screening/History, dated 3/4/16, indicated the resident had a Stage II pressure ulcer on his coccyx and measured 1.0 x 1.0 x 0.1 cm.</p> <p>A Wound Assessment, dated 3/9/16, indicated the Stage II coccyx pressure ulcer measured 1.0 x 0.5 x 0.1 cm and had scant yellow drainage. The assessment indicated the wound was larger after his return from the hospital on 3/4/16.</p> <p>The Treatment Administration Record (TAR) indicated the resident had not received wound care and/or dressing changes on 2/26, 2/27, 2/28 and 2/29/16. The Director of Nursing (DON) was</p>		<p>regarding the possibility of obtaining mental health counseling for him and to assist staff with a better understanding of his behaviors and ways to redirect those behaviors when they occur. The DON asked the family for consent for this counseling shortly after the resident was admitted, and the family declined at that time. The DON will document the family's response to her request in the resident's chart. All staff will be in-serviced on the behavior management system, including documentation and the use of the behavior log for all behaviors being observed and tracked for each resident. The staff will also be trained to utilize the Social Services Referral form to communicate resident needs to the Social Services Director, including interventions that have not been successful in redirecting a resident's behavior. Additional outside consultation will be scheduled for the Social Services Director to clarify any questions that she may have regarding the facility's behavior management system, and to provide an additional resource for identifying specific resident behaviors & approaches. In addition, the interdisciplinary team will be re-trained by the nurse consultant on the importance of updating resident's care plans as behaviors are identified, as behaviors change, and as</p>		

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	<p>unable to locate a treatment order and/or dressing changes for the Stage II coccyx pressure ulcer when the resident was admitted on for 2/26.</p> <p>On 3/14/16 at 11:32 A.M., the Nurse Consultant provided a policy titled " Admission Assessment - Nurse" and indicated the policy was the one currently used by the facility. The policy indicated "16. Examine extremities and note: a. Condition of skin; b. Open area...17. Document all skin abnormalities."</p> <p>3. On 03/08/2016 at 12:06 P.M., Resident "B" was observed to have a purple oval area on his left upper forearm/elbow area.</p> <p>On 3/10/16 at 2:47 P.M., a review of the clinical record for Resident "B" was conducted. The record indicated the resident was admitted on 3/5/1998. The resident's diagnoses included but was not limited to; mental retardation, hypothyroidism, cerebral palsy and abnormal posture.</p> <p>A care plan, dated 7/26/12, indicated the resident was at risk for bruising due to leaning in his wheelchair (w/c). The interventions included, but were not limited to: weekly skin assessments, notify MD (medical doctor) as needed, ensure harness in w/c fits properly with</p>		<p>interventions are added, revised, and deleted. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by these practices. If any member of the IDT becomes aware of nutritional issues, such as weight loss; residents with skin areas that are not being addressed; bowel and bladder assessments that are not finalized; dialysis residents without documentation from the dialysis center or from the nurse on duty when the resident returns to the facility; lack of splint or ROM use for residents with contractures; inaccurate MDS documentation; or lack of assessment of behaviors or communication of specific interventions when dealing with behaviors, he/she will report the issue directly to the Administrator and DON, who will begin an investigation immediately to resolve the issue as quickly as possible. Once the resident is taken care of, the DON, Administrator, or other involved IDT member will re-train the staff involved in the issue. Progressive written counseling will be rendered as indicated by the situation. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> If the Dietary Services Manager finds a weight with questionable</p>				

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	<p>application, and side rails padded for seizure activity. Another care plan indicated the resident leans to the right while in his w/c and it was the resident's preference to lean in the w/c so he could propel himself.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 1/12/16, indicated the resident's Brief Interview Mental Status (BIMS) score was 10, moderate dementia. The MDS assessment indicated the resident was totally dependent on staff for bed mobility, transfers, dressing, toileting and with personal hygiene.</p> <p>A Nurses Weekly Summary, dated 3/5/16, indicated the resident had no new changes to skin integrity. Another Nurses Weekly Summary, dated 3/13/16, indicated the resident had no new changes to his skin integrity.</p> <p>On 3/14/16 at 2:00 P.M., the resident was observed to have a oval light purple-yellow area on his upper left forearm/elbow and measured approximately 5 centimeters.</p> <p>During an interview, on 3/14/16 at 8:50 A.M., the Director of Nursing (DON) indicated she was aware of Resident "B's" bruise last week and had contacted</p>		<p>accuracy, she will report it to the charge nurse and request that the resident be re-weighted. If the resident is found to have aweight loss that is significant, the DSM will contact the dietitian for recommendations by telephone. The Dietary Services Manager will also notify the IDT members at the next scheduled IDT morning management meeting which occurs at least 5 days a week for further review. The resident will be weighed weekly and reviewed in the Nutrition-at-Risk meeting that also meets weekly. The dietitian will assess the resident at least monthly during her scheduled visits and will supply recommendations as needed. The physician will be contacted and the orders will be transcribed and added to the residents' plan of care. This oversight and monitoring will continue until the resident's weight and nutritional status have stabilized, as determined by the dietitian and other members of the team. If open areas, bruises, or other skin issues are identified, the nurse will assess each one with documentation of the area,including size and full description of each area. The physician is to be notified of any unusual skin issue and any orders that are received will be transcribed by the nurse receiving the orders, including documentation on the TAR for</p>		

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	<p>his Level 2 specialized work representative to inquired about the bruise. The DON indicated the representative wasn't aware of the resident's bruise. The DON indicated she wanted to know if his work area might be the cause of the bruise. The DON indicated she was unable to identify the cause of the bruise. The DON also indicated the bruise had not been assessed, measured or documented on in the resident's chart and conversation with the representative from Resident's specialized service program was not documented.</p> <p>During an interview on 3/14/16 at 11:50 A.M., the DON indicated her expectation would be the nurse who did the assessment (weekly summary) on 3/13/16 would have documented the bruise on the Resident's left upper forearm/elbow area. She didn't believe the bruise was there on the 3/5/16 weekly assessment as she first observed the bruise on Wednesday the 9th of March. She indicated she thinks the process of assessments was dropped when the facility changed from paper charting to electronic charting.</p> <p>On 3/14/16 at 11:55 A.M., the Nurse Consultant provided the policy titled "Non-Pressure Skin Conditions," dated January 2005 and revised on October</p>		<p>administration of treatments. An emphasis will be placed on making sure that physician orders are put into the electronic medical records system and they each is followed through by all nurses to make sure that the residents are receiving what the physician has ordered. If the DON or other IDT member finds that an assessment has not been completed or followed up by staff as necessary, they will notify the DON (if she is not already aware) who will make sure that the assessment is done as quickly as possible, with the results followed through as needed and reflected on the resident's care plan. If the DON or other IDT member finds that a resident has a contracture or other lack of mobility in one of his/her extremities and does not have a splint or is not receiving treatment, such as ROM, the DON will talk with the resident and notify the therapy provider for evaluation of the resident's condition. If the resident declines the use of a splint or does not want to receive ROM or other type of treatment, that choice will be documented in the resident's record and in the resident's care plan. The Social Service Director and other interdisciplinary members of the Behavior Committee will audit behavior logs to make sure that listed behaviors on the log are current and that all interventions are current, including any that have</p>		

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	<p>2011, and indicated the policy was current. The policy indicated a licensed nurse will assess and document all non pressure skin conditions. Definition: "... A non-pressure skin condition is one that does not meet the criteria of pressure ulcers or venous, arterial or diabetic ulcers Stage 1 - IV. Examples of non-pressure conditions include, but are not limited to: rashes, excoriation, bruises, skin tears, open lesion, abrasions, laceration, and surgical wounds...."</p> <p>4. During the initial tour, on 3/7/16 at 9:50 A.M., Resident #47's indwelling Foley catheter was observed from the hallway.</p> <p>During an interview, on 3/7/16 at 2:57 P.M., an Agency Nurse #1 indicated Resident #47 did not have an indwelling Foley catheter nor a pressure ulcer. The Agency Nurse #1 indicated the resident had gone to the hospital and returned and she just wasn't sure if the Resident returned to the facility with a Foley catheter or not. She indicated the justification of the use of the Foley catheter was incontinence.</p> <p>On 3/9/16 a 9:22 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was admitted on 2/26/16 and</p>		<p>been developed as per the recommendation of the mental health providers. Once all logs are updated, the residents' care plans and CNA assignment sheets will be updated, as well. All members of the IDT will observe the staff's attempts at redirecting behaviors for evidence that each staff person involved is following the interventions care planned for that resident and behavior, and that he/she has done accurate & complete documentation of the behavior on the behavior log. If any staff member is observed not to follow the care planned interventions for a resident who is experiencing a behavior, the Social Services Director and/or IDT member will intervene immediately to make sure that the resident's behavior is managed according to the planned interventions. Once the resident's behavior has subsided and the resident's safety is assured, the Social Services Director and/or IDT member will re-train the staff involved regarding the behavior log, the care plan, and its use. In all of these areas mentioned in the 2567, the DON and Administrator will make sure that any identified issue will be addressed as quickly as possible for the resident's health and safety. Once that is assured, the staff members involved in the issue itself will receive re-training and possible written counseling, depending on</p>				

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	<p>readmitted on 3/4/16. The resident's diagnoses included but was not limited to: adult failure to thrive, chronic obstructive pulmonary disease, diabetes, chronic embolism/thrombosis of deep veins of lower extremity (bilateral) and congestive heart failure.</p> <p>The care plans, dated 3/2/16, indicated the resident did not wish to attend any activities and wished to have supervised smoking privileges. There was no plan of care for the use of an indwelling Foley catheter for Resident #47 after his re-admission to the facility on 3/4/16.</p> <p>The physician orders, dated 3/4/16, from the hospital did not contain an order an indwelling Foley catheter.</p> <p>The Treatment Administration Record (TAR) did not contain a treatment for Foley catheter care/cleaning.</p> <p>During an interview, on 3/10/16 at 2:00 P.M., MDS (Minimum Data Set) Consultant #2 indicated an Interim Care Plan should be completed by the admitting nurse. She further indicated the resident's care plans will continue to be developed with MDS admission and 14-day assessments.</p> <p>On 3/11/16 at 12:10 P.M., the DON</p>		<p>the situation itself. 3. The DON has done 100% audit of residents' skin and documented her assessment of any issues that were found including notification of family and physician. The DON/designee will measure and document on all skin concerns weekly until healed. The DON will audit the assessments 5 times a week for 30 days and bring morning management meeting and complete auditing tool F272/514 with her findings. All new orders will be audited by the DON 5 times a week for accuracy. New admission and re-admission orders will be checked by 2 nurses and progress note documenting this occurred. The Director of Dietary Services will be doing a weekly audit of weights and will bring her findings on the Weight Audit tool to the weekly Standards of Care meeting for IDT to review.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or other designated members of the IDT will bring the result of their audits to the weekly Standards of Care meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the assigned member of the IDT and the results of those recommendations will be brought back to the next</p>	

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	<p>provided a current policy titled "Catheter Care - General Information," dated June 2004. The policy indicated "5. Cleaning a. Inspect the area around the urethral orifice and catheter at least 1 time per shift for cleanliness and dryness...." The policy did not address the need to have an order for the use of an indwelling Foley catheter.</p> <p>5. The clinical record for Resident #31 was reviewed on 3/9/16 at 10:15 A.M. Resident #31 was admitted to the facility, on 2/6/12, with diagnoses, including but not limited to : Alzheimer's disease, adult failure to thrive, diabetes mellitus type II and osteoarthritis of the hip.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 1/5/16, indicated the resident was severely cognitively impaired, required total dependence two plus person assist with transfers and toilet use and extensive two person physical assist for bed mobility. The resident was documented as always incontinent of her bladder. A bowel and bladder assessment could not be located on the paper or electronic charting for Resident #31.</p> <p>A care plan, dated 1/7/16, indicated the resident was incontinent of both bowel and bladder due to Alzheimer's disease. The interventions included, but were not</p>		<p>scheduled QA Committee meeting for review. When the written audits have shown 100% compliance, the QA Committee may decide to stop them; however, the monitoring by the IDT members will continue as indicated on an ongoing basis.</p>				

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	<p>limited to: I am to be cleansed and dried after each incontinent episode. I require staff to check and change me every two hours and as needed. I want to wear a brief to maintain my dignity. I will have a bowel and bladder assessment completed upon admission/readmission, quarterly, annually, with significant changes and as needed.</p> <p>On 3/9/16 from 8:05 A.M. to 9:03 A.M., Resident #31 was observed seated in her Broda (reclining wheelchair) chair in the assisted dining room, the staff was feeding the resident her breakfast. At 9:04 A.M., the resident was taken by staff from the assisted dining room and placed in the hallway outside of her room. At 9:10 A.M., the resident was taken in her Broda chair by the Activity Director for a walk in the hallway. At 9:15 A.M., the Activity Director brought the resident back to her room and placed the resident in the hallway outside of her room where she remained until 10:22 A.M. when the Activity Director assisted the resident in her Broda chair to the dining room for an activity. At 11:09 A.M., the resident was assisted by the Activity Director from the main dining room into the assisted dining room. The resident remained in the assisted dining room until 1:15 P.M. At 1:15 P.M., the resident was propelled in her Broda chair by a CNA (Certified</p>			

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	<p>Nursing Assistant) and placed in the hallway outside of her room. From 1:15 P.M. to 3:15 P.M., the resident remained outside of her room in the hallway seated in her Broda chair. At no time was the resident observed to be checked or changed. At 3:20 P.M., CNA #25 was questioned if the resident ever lays down in the afternoon the CNA indicated "sometimes." At 3:25 P.M.. CNA#25 and CNA#26 assisted Resident #31 into bed with the use of the hooyer lift. As the resident was lifted from her Broda chair there was a strong foul smelling urine odor, the pressure relieving cushion in the Broda chair was wet, the resident's light tan slacks had a large wet stain on the back of them. The brief was saturated with a strong foul smelling urine odor, the resident had a moderate amount of soft brown bowel movement in the brief. A Mepilex dressing to the coccyx area was wet with urine and the dressing was coming off of the coccyx area. LPN (Licensed Practical urse) #27 came into the room to remove the soiled dressing to the coccyx and apply a new dressing. LPN #27 indicated the resident had a pressure area on her coccyx but it was healed now the dressing continues to the area for protection. The skin to the coccyx was observed no open areas was observed.</p>			

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	<p>On 3/10/16 at 10:00 A.M., RN (Registered Nurse) #20 provided a policy titled "Bladder Incontinence Program", dated 5/2006, and indicated the policy was the one currently used by the facility. The policy indicated "...Bladder Assessment...4. Once the form is completed, the MDS Coordinator will add the appropriate bladder program to the resident's plan of care, nursing assistant assignment sheets, and other relevant documents, such as ADL [Activities of Daily Living] sheets, restorative nursing forms, & 24 hour report form to assure staff knowledge and follow through...5...Reassessment will occur at least quarterly after that, as indicated by the resident's condition and the outcome of the bladder program...."</p> <p>During an interview, on 3/14/16 at 10:44 A.M., the Director of Nursing indicated the resident should be checked and changed after each meal, at HS and as needed. She further indicated she was unsure why a bladder assessment had not been completed on this resident. She indicated the MDS assessment nurse should have completed it to correlate with the 1/5/16 MDS assessment. She indicated the quarterly update should be on the back of the bladder assessment and the assessment should be on the paper chart.</p>			

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	<p>6. A clinical record review was completed on 3/9/2016 at 12:25 P.M., for Resident #11. The clinical record indicated Resident #11 was admitted on 2/8/2016. The diagnoses included but were not limited to: kidney failure, secondary hypertension and peripheral vascular disease.</p> <p>A care plan, dated 2/19/2016, indicated "...Ask the dialysis center to send documentation back to the facility, with me, of anything that they have done for me during my dialysis visit..." and "...Nursing to complete my post dialysis assessment after I return from dialysis...."</p> <p>During an interview on 3/9/2016 at 2:45 P.M., the DON (Director of Nursing) indicated the facility does not have any documentation related to communication with the dialysis center and unable to locate any orders to monitor the residents dialysis access site.</p> <p>During an interview on 3/10/2016 at 10:45 A.M., LPN #3 indicated the facility did not have a form of communication related to dialysis services or assessments for Resident #11. She further indicated that there was no form of documentation she could access at the facility to inform her of the assessments performed at the</p>			

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	<p>dialysis center for Resident #11.</p> <p>On 3/7/2016 at 2:00 P.M., the DON provided a dialysis contract titled " SNF [Skilled Nursing Facility] OUTPATIENT DIALYSIS SERVICES AGREEMENT," dated July 1, 2013, and indicated this was the contract used for Resident #11. The contract indicated "...D. Mutual Obligations 1. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and ESRD [End Stage Renal Disease] Dialysis Unit. Documentation shall include, but not be limited to, participation in care conferences, continual quality improvements program, annual review of infection control of policies and procedures, and the signatures of team members from both parties on a Short Term Care Plan (STCP) and Long Term Care Plan (LTCP). Team members shall include the physician, nurse, social worker and dietitian from the ESRD Dialysis Unit and a representative from the Nursing Facility. The ESRD Dialysis Unit shall keep the original the STCP and LTCP in the medical record of the ESRD Resident and the Nursing Facility shall maintain a copy...."</p> <p>On 3/10/2016 at 11:15 A.M., the</p>			

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	<p>Coporate Nurse provided the policy titled "Hemodialysis," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated "...GUIDELINES: The Dialysis Unit should provide a written progress note of some type regarding the pertinent issues that were observed or occurred during the dialysis visit. It should also include the amount of fluids that the resident consumed during his/her visit...." and "...6. Assess resident upon return from dialysis and document findings on Post Dialysis Assessment form. If there are additional observations, the nurse will document them in the residents's chart...." and "...Document resident's status on the Post Dialysis Assessment form when returning from dialysis...."</p> <p>7 . A clinical record review was conducted on 3/9/2016 at 8:53 A.M., and indicated Resident "I" was admitted on 10/27/2015. The diagnoses included but were not limited to: chronic obstructive pulmonary disease, arteriosclerosis of autologous artery coronary artery bypass graft with other forms of angina pectoris, major depressive disorder recurrent mild anxiety disorder, age related osteoporosis without current pathological fracture, edema, insomnia, muscle weakness, and mood disorder due to known psychological condition with depressive</p>			

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	<p>features.</p> <p>A MDS (Minimum Data Set) assessment completed on February 2, 2016, indicated Resident "I" had a decline in bladder continence.</p> <p>There was no documentation in the record related to a a bladder assessment related to Resident "I's" current bladder needs.</p> <p>During an interview on 3/9/2016 at 9:34 A.M., the DON (Director of Nursing) indicated that Resident #38 should have had a bladder assessment completed, however she was unable to locate a completed bladder assessment for Resident "I".</p> <p>On 3/10/2016 at 10:00 A.M., the Coporate Nurse provided the policy titled "Bladder Incontinence Program," dated May 2006, and indicated this was the policy currently used by the facility. The policy indicated "...POLICY: Any resident identified as incontinent of urine will be evaluated for causal factors and appropriate actions will be undertaken to obtain the most effective results, depending on the source and cause of the incontinence...."</p> <p>8. On 3/9/2016 at 8:49 A.M., Resident #9</p>			
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	<p>was observed to be sitting in her bed without the use of a splint.</p> <p>During an interview on 3/7/2016 at 3:14 P.M., Nurse #2 indicated Resident #9 had a contracture to her right arm due to a stroke. She indicated she was unsure if Resident #9 received any ROM (range of motion) exercise or had any splint devices in place.</p> <p>A clinical record review was completed on 3/10/2016 at 11:11 A.M., for Resident #9. Resident #9 was admitted on 6/19/2014. The diagnoses included, but were not limited to: nontraumatic intracerebral hemorrhage and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, hemiplegia unspecified abnormalities of gait dominant side and muscle weakness.</p> <p>There was no documentation related to an assessment for the use of splint devices or ROM (range of motion) exercises for Resident #9s' contracture to her right arm.</p> <p>An MDS (Minimum Data Set) assessment, dated March 9, 2016, indicated Resident #9 has no limitation to her upper or lower body.</p> <p>On 3/10/2016 at 11:29 A.M., Resident #9</p>			

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	<p>was observed with her right arm at her right side. No movement of her right arm was observed.</p> <p>During an interview on 3/11/2016 at 11:24 A.M., the DON (Director of Nursing) indicated Resident #9 should have a care plan addressing her refusal of any type of treatment to her right arm. She indicted Resident #9 was unable to move her right arm and the MDS (Minimum Data Set) assessment should reflect this, however it does not.</p> <p>A policy was provided by the corporate nurse on 3/14/2016 at 10:45 A.M., titled "Prevention of Pressure Ulcers," dated January 2005, and indicated this was the policy currently used by the facility. The policy indicated "...CONTRACTURES: Contractures, which cause shortened and flexed positions of the affected area, develop in predictable patterns, so splinting, range of motion exercises, and proper positioning can help prevent their occurrence. Such prevention is necessary not only because of the loss of strength and function they cause, but also because they may compromise positioning and hygiene. In addition, significantly contracted limbs are thought to result in impaired blood supply to that limb - which should raise a red flag, since pressure ulcer development has its</p>			

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	<p>origins in impaired blood flow and resultant tissue ischemia. Although a contracture will not necessarily result in a pressure ulcer, healing a of a pressure ulcer that does erupt will be complicated by the poor perfusion of the limb...."</p> <p>9. A clinical record review was completed for Resident "G" on 3/10/2016 at 3:37 P.M., and indicated Resident was admitted on 12/31/2015. The diagnoses included, but were not limited to: abnormal posture, aphasia, dysphagia oropharyngeal phase, cramp and spasm, traumatic cerebral edema with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, conversion disorder with seizures or convulsions, insomnia due to medical condition, atelectasis, parkinsonism, muscle weakness and major depressive disorder.</p> <p>There was no documentation related behavior assessment for inappropriate behaviors for Resident "G."</p> <p>A behavior log was reviewed from the Social Service Director on 3/11/2016 at 9:30 A.M., and indicated Resident "G" had no behaviors documented for the months of January, February, or March 2016.</p>			

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	<p>During an interview on 3/11/2016 at 9:38 A.M., the Social Service Director indicated that she was unaware that Resident "G" was having any inappropriate behaviors. She further indicated that the behaviors listed in the behavior log were the only behaviors Resident #43 experienced.</p> <p>During an interview on 3/11/2016 at 9:44 A.M., LPN (Licensed Practical Nurse) #2 indicated Resident "G" will sometimes "grab" at staff. She indicated when he does this staff turn their bodies away from him to prevent contact.</p> <p>On 3/11/2016 at 10:39 A.M., observation of Resident "G" indicated he is capable of intentional movements at times. He was further observed to have the ability to handwrite using a pen and paper.</p> <p>On 3/13/2016 at 11:25 A.M., the Corporate Nurse provided the policy titled "Behavior Management & Monitoring Program," dated October 2007, and indicated this was the policy currently used by the facility. The policy indicated "...5. The interventions that guide the staff on how to deal with a problem behavior when it occurs will be found on the Behavior Monitoring Record. The Behavior Log form will be used to document each observed episode</p>			

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	<p>of the targeted behavior. It will record the following information: date, time, behavior, precipitating events, staff interventions, and outcome...."</p> <p>10. A clinical record review was completed on 3/9/2016 at 12:25 P.M., for Resident #11. Resident #11 was admitted on 2/8/2016. The diagnoses included, but were not limited to: kidney failure, muscle weakness, difficulty in walking, arthropathy, arterosclerotic heart disease of native coronary artery without angina pectoris, secondary hypertension and peripheral vascular disease.</p> <p>A care plan, dated 2/19/2016, indicated "...Observe my feet with baths and weekly skin assessments to ensure no other issues are occurring...." and a care plan dated 2/25/2016 indicated "...My skin condition will be monitored at least twice a week by the CNA [Certified Nursing Assistant] during my shower and weekly by the charge nurse...."</p> <p>A form titled "Licensed Nurse Weekly Skin Assessment, dated 2/9/2016, indicated Resident #11 did not have an area to his great toe.</p> <p>An MDS (Minimum Data Set) assessment, dated 2/18/2016, indicated</p>			

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	<p>Resident #11 had a diabetic foot ulcer and other open lesions on the foot.</p> <p>During an interview on 3/10/2016 at 9:44 A.M., the DON (Director of Nursing) indicated there was no documentation available regarding the area to Resident #11's great toe. She further indicated she was unaware of any area to his great toe and she was only aware of an are to his outer foot on admission and the area was "washed away due to it was dirt."</p> <p>On 3/10/2016 at 10:01 A.M., an observation of Resident #11s' feet indicated he had a scabbed area to his right great toe. The area was observed to have a scab in the middle and surrounded by reddened skin. The DON (director of nursing) indicated she would document her assessment of Resident #11s great toe and would be measuring it weekly "from this point on".</p> <p>During an interview on 3/10/2016 at 12:23 P.M., the Corporate Nurse and the DON (director of nursing) indicated there was not any documentation related to Resident #11 receiving a shower at the facility. The DON indicated Resident #11 was to receive skin checks with showers and those have not been done.</p> <p>A policy was provided by the corporate</p>			

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	<p>nurse on 3/14/2016 at 11:36 A.M., titled " Change of Condition -ICF/MR [Intermedicate Care Facility/Mentally Retarded]" dated March 9, 2015, and indicated this was the policy currently used by the facility. The policy indicated "...All staff members shall communicate any information about resident status change to appropriate licensed personnel immediately upon observation...." A policy was provided by the corporate nurse titled " Skin Assessments," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated "...PROCEDURE: 1. Head to toe assessments will be done weekly, with special attention being addressed to areas more prone to skin breakdown, such as ears, shoulder blades, elbows, coccyx, buttocks, heels, outer aspect of feet, inner aspect of feet...."</p> <p>11. On 3/9/2016 at 3:00 P.M., Resident #32 was observed to have an open area to his left arm. The area was located on the underside of his forearm. Resident #32 was observed multiple times leaning in his wheelchair putting pressure on his left arm for extended periods of time.</p> <p>A clinical record review was completed on 3/10/2016 at 8:45 A.M., for Resident #32. Resident #32 was admitted on 8/28/2015. The diagnoses included, but</p>			

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	<p>were not limited to: complete traumatic amputation of one unspecified lesser toe, muscle wasting and atrophy not elsewhere classified unspecified site, atrial fibrillation, muscle weakness, heart failure, pressure ulcer of unspecified site, atresia of esophagus with tracheo-esophageal fistula, dementia, behavioral disturbance, acquired absence of unspecified great toe, gangrene, anemia, colostomy, hypertension, type 2 diabetes mellitus, and other specified diabetes mellitus with other skin complications.</p> <p>A care plan, dated 1/28/2016 at 8:59 A.M., indicated "...I need any changes in my skin to be reported to the MD [Medical Doctor] immediately..."</p> <p>A weekly summary, dated 2/12/2016, indicated Resident #32 had no new skin issues.</p> <p>A weekly summary - licensed nurse, dated 3/1/2016, indicated Resident #32 had no new skin issues.</p> <p>A form titled "ASSESSMENT OF OTHER SKIN ABNORMALITIES," dated 3/10/2016, indicated Resident #32 had an area to his left outer arm 8 cm (centimeter) x 6 cm and red in color. The form indicated "...Area red. First layer of</p>			

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	<p>skin gone. No s/s (signs or symptoms) of infection. Denies pain Refused measurements. Dressing applied...." The form indicated there was a new order for Mepilex (a type of dressing) to be changed every three days.</p> <p>On 3/10/2016 at 8:49 A.M., Resident #32 was observed to have a bandage on his left arm. The bandage was observed to be loose and falling off. Drainage was observed to the outside of the bandage.</p> <p>On 3/15/2016 at 10:28 A.M., Resident #32s' bandage to his left arm was observed to be dated 3/9/2016.</p> <p>During an interview on 3/10/2016 at 10:28 A.M., the Corporate Nurse indicated there was no documentation on the area found yesterday to the Resident #32s' left arm.</p> <p>During an interview on 3/10/2016 at 10:55 A.M., the DON (Director of Nursing) indicated there was no documentation of an assessment completed on Resident #32s' left arm nor was there any documentation of contacting the physician.</p> <p>During an interview on 3/15/2016 at 10:32 A.M., the DON indicated that the dressing was placed on 3/9/2016 and</p>			

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	<p>should have been changed on 3/12/2016. She indicated the dressing order was to change the residents dressing every three days.</p> <p>On 3/10/2016 at 10:00 A.M., the Coporate Nurse provided a policy titled "Dressing Change, Clean and Sterile," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated "...PURPOSE: To protect open wound from contamination. To prevent irritation. To prevent infection and spread of infection. To absorb and contain drainage...."</p> <p>On 3/14/2016 at 11:36 A.M., the Coporate Nurse provided the policy titled "Change of Condition - ICF/MR [Intermediate Care Facility/Mentally Retarded]," dated March 9,2005, and indicated this was the policy currently used by the facility. The policy indicated "...Documentation in the nurses' notes is required each shift on any resident who experiences a problem, demonstrates a symptom or any change of status. Documentation must continue each shift for at least 24 hours, and usually 72 hours, after the problem is identified, then daily until the problem is noted as resolved...."</p>			

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F 0280 SS=D Bldg. 00	<p>3.1-31(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interviews, the facility failed to ensure a plan to prevent falls was updated timely for 1 of 3 residents reviewed for accidents. (Resident "E")</p> <p>Finding includes:</p> <p>The closed clinical record for Resident</p>	F 0280	<p>It is the policy of this facility to assure that care plans are updated to reflect interventions for identified resident needs, including those for fall prevention.</p> <p>1. <u>What corrective action will be done by the facility?</u> The care plan for Resident E has been updated in conjunction with the interdisciplinary team's (IDT) input The Interdisciplinary team will be in-serviced by the Nurse</p>	04/15/2016
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	<p>"E" was reviewed on 03/11/2016 at 11:08 A.M. Resident "E" was admitted to the facility on 01/02/12 with diagnoses, including but not limited to: vascular dementia without behaviors, muscle weakness, hypertension, pulmonary collapse, chronic gout and chronic obstructive pulmonary disease.</p> <p>A nursing progress note, dated 02/07/16 at 23:00 (11:00 P.M.), indicated the resident was heard yelling "Help me I fell. " The resident was found in his room, lying in a prone position on floor by the other bed in his room. The resident had a laceration to his scalp. The resident informed the emergency medical transport staff he fell out of his bed but told the nurse he fell ambulating to the bathroom.</p> <p>A care plan related to fall risk, initiated on 12/31/15, indicated there were no interventions implemented to prevent further falls after the resident fell on 02/07/16.</p> <p>A fall assessment form, completed on 02/07/16 and revised on 02/17/16, indicated the resident was oriented, had gait issues, was utilizing a walker, had pain issues and poor lighting when he fell. There were no recommendations noted on the fall investigation form.</p>		<p>Consultant regarding the need to update all resident care plans as each one's condition changes, including those who experience falls, making sure that interventions are added, revised, or deleted as indicated by the resident's status. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice, especially residents who experience a fall. The DON and Nurse Consultant have reviewed the care plans of residents who have fallen since the 3/1/16 to make sure that each care plan contains interventions that were reviewed and revised as necessary after the fall. In the future, if any member of the IDT finds a care plan without updated and/or revised interventions when a resident has fallen, he/she will bring that resident situation to the next scheduled morning management meeting which occurs at least 5 times a week for review by the IDT members. Once the care plan is updated, the CNA assignment sheets will be updated as well. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The DON will bring any resident who has fallen to the next scheduled IDT morning management meeting which meets at least 5 times per week</p>	

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	<p>A nursing progress note, dated 02/09/16 at 2:05 A.M., indicated Resident "E" was heard yelling "Help" at 12:30 A.M. and was found lying in the hallway by the bathroom. The resident had no visible injuries and he was assisted to walk with his walker back to his room. A audible alarm was placed on the resident.</p> <p>During an interview on 03/15/16 at 3:30 P.M., the Director of Nursing indicated the resident was to utilize and wheelchair and was to be working with therapy. She indicated his walker was left in his room, the care plan was not updated and he did fall again on 02/09/16. She indicated once the resident's walker was removed from his room he did not attempt to get up out of bed by himself anymore.</p> <p>This Federal tag relates to Complaint IN00193960.</p> <p>3.1-35(d)(2)(B)</p>		<p>for review of the incident by the IDT members. The circumstances of the fall will be discussed by the IDT and the resident's care plan will be reviewed for appropriate interventions to prevent future falls. Any change in interventions will be dated to show when each was added, deleted, or revised. The CNA assignment sheets will be updated as well at that time to include any changes in the interventions for the resident. The Nurse Consultant will review the care plans of residents who have experienced a fall since her last visit to make sure that the care plans are current and will re-train the IDT members for any that she finds out of compliance. The Nurse Consultant will visit the facility at least weekly for the next 60 days, then at least twice a month from that point on to ensure regular follow up. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> In addition to the IDT morning management meeting, residents who have fallen and the resulting interventions for fall prevention will be reviewed by the IDT at the weekly Standards of Care meeting. Changes in interventions will be done at that time for any identified issues. The DON will discuss the residents who have fallen and the interventions that have been put into place at the</p>				

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F 0282 SS=E Bldg. 00	<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, record review and interview the facility failed to ensure physicians orders for medications and treatments were followed for 5 of 31 residents for whom physician's orders were reviewed. (Resident "D", "H", #32, #47, and #49). In addition, the facility failed to ensure care plan interventions were followed for toileting, pressure relief, or dialysis needs for 4 of 31 residents whose care plans were reviewed. (Resident #6, "F", #31 and #11)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #49 was reviewed on 03/15/2016 at 2:58 P.M. Resident #49 was admitted to the facility</p>	F 0282	<p>monthly QA Committee meeting for further review and recommendation from the members. If any recommendations are made, the DON will follow up and report the results of the recommendations back to the QA committee at the next month's meeting. This will continue on an ongoing basis. Date of Compliance: 4/15/16</p> <p>It is the policy of this facility to ensure that physician orders for medications and treatments are followed, and that care plan interventions for toileting, pressure relief, and dialysis needs are followed.</p> <p><u>1.What corrective action will be done by the facility?</u> The treatment orders for Resident #49 have been transcribed properly and are being administered and documented as ordered.The resident's care plan has been updated to reflect the treatments that she is receiving. The status of the skin condition on her body is assessed and documented weekly. The facility is making arrangements for Resident #49 to be seen by a podiatrist, as per her request. Resident D is no longer a resident of this facility.</p>	04/15/2016	

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	<p>on 03/09/16, with diagnoses, including but not limited to: Alzheimer's disease, atherosclerotic heart disease, diabetes mellitus, hypothyroidism, gastro-esophageal reflux disease, hyperlipidemia, vascular dementia with behavioral disturbance, syncope and collapse, and hypertension.</p> <p>The intial nursing assessment, completed on 03/09/16 at 23:09 (11:09 P.M.), indicated there were no skin issues noted on the assessment.</p> <p>A Weekly skin assessment, completed on 0310/16, indicated the resident's lower legs bilaterally present with "thick scaly skin." The resident stated she was being treated for them at the hospital with daily cleaning with a wound wash only, no water then a moisture cream and protective leggings. The note indicated there was no edema and no wounds present.</p> <p>The discharge orders from the hospital for Resident #49, dated 03/09/16, indicated the following:</p> <p>*"skin integrity. BLE [bilateral lower extremities] with hyperkeratosis, moisture breakdown in pannus fold and under breast."</p>		<p>The licensed nurses will be in-serviced on the appropriate transcription of physician orders for medications, so that they can be given as directed by the physician by 4/15/16. Resident #6 has a referral to therapy for assessment of his wheelchair seating to make sure that it is appropriate to his needs. The nursing staff will be reminded that even though Resident #6 often refuses to move from the wheelchair for any reason, including toileting, they are to always check him for changing and/or ask him if he would like to go to the bathroom. His care plan has been updated to reflect this approach, as well as his frequent refusal to move from the hallway to receive blood glucose checks or administration of insulin. Resident #47 is no longer a resident of this facility. Nurses will be in-serviced about obtaining admission orders,including specific orders for PICC lines; orders for the use, care, and treatment of Foley catheters as well as any medications or treatments that the physician wishes to hold for a certain period of time. In addition to transcribing all orders received by the physician, the nurses and IDT will be in-serviced on making sure that the care plans are reflective of these services and treatment. Resident #31 will have a new bowel and bladder assessment done by 4/15/16. Based on the</p>		

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	<p>*Additional skin care/wound treatments BLE BID (twice a day)</p> <p>*Skin Care Supplies Sent with Patient BAZA (Antifungal) Cleanse and Protect Lotion Cleanser, Baza Clear Barrier Ointment, cotton stockinet</p> <p>*Additional Information Wound care included: BLE: Cleanse skin thoroughly with Baza cleanse and protect and washcloth. Apply Basza Clear ointment liberally to legs and feet. Place cotton stockinet sock to knees to keep ointment from being rubbed off. Perform care BID.</p> <p>*Pannus/Breast fold: Cleanse under pt (patient) pannu and breasts with Baza cleanse and protect and pat dry. Place Interdry AG (Absorbant fabric with antimicrobial Silver Complex) in pannus fold, place to fold line and lay in single layer. Allow 1-2 inches of fabric to remain exposed from under skin to wick moisture out of area. Do not use any other powders or creams with Interdry as it can clog the "pores" of the fabric and decrease effectiveness. May change out PRN (as needed) and rinse fabric with plain tap water and allow to air dry for reuse. Perform Care BID.</p> <p>The Medication and Treatment</p>		<p>results of that assessment, the care plan will be updated to accurately reflect the status of the bladder and bowel functions, including an individualized plan to check, toilet, and change the resident on a frequent basis in order to keep skin as clean and dry as possible. Nursing staff will be in-serviced by the DON and Nurse Consultant on completion and timeliness of bowel and bladder assessments, as well as</p> <p>2.inclusion on the residents' plans of care. For Resident F a new bladder assessment will be done by 4/15/16. At this time, he has demonstrated consistent continence, and his care plan will be adjusted to the results of the bladder assessment to demonstrate his current status, including the restorative nursing program for toileting. That program will be listed on the CNA assignment for staff reference when toileting him. Resident F has received appropriate personal care since the survey. This resident has a tendency to move throughout the facility on his own when up, and staff will be in-serviced on the need to assist him with his own personal care throughout the day on a routine basis. The Nurse Consultant will in-service the IDT members regarding the Guardian Angel Program and the observations that they should be making for the residents that are assigned to them, including the status of each</p>	

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	<p>Administrator Record for Resident #49 for March 2016, reviewed on 03/12/16 at 5:00 P.M., indicated there was no documentation of the skin treatments on the forms.</p> <p>During an interview on 03/12/16 at 5:50 P.M., the Director of Nursing (DON) indicated the wound care had not been done. She indicated the resident had "dry skin" but no other skin issues on her pannus fold or legs. The Director of Nursing indicated she had given the resident some Lavender scented lotion to use on her dry skin. There was no explanation given as to why the wound care orders had not been implemented.</p> <p>On 03/14/2016 at 930 A.M., Resident #49's feet and legs were observed in her room with the Director of Nursing. Resident #49 was noted to have long yellow thick gripper type socks and a very soiled stockinet underneath the socks on both legs. As the resident attempted to pull the socks and stockinet down, large chunks of thick, brown colored dried skin fell onto the floor. The stockinet had a slightly yellowed tinge and multiple black colored chunks and crumbs of dried skin stuck to them. The resident's left and right leg from the knee clear through her feet were covered with a thick dried alligator looking</p>		<p>one's personal care each time that they visit. Resident #11 is no longer at the facility and there are no other residents requiring dialysis at this time. However, the nurses will be in-serviced in the use of the post-dialysis documentation form, which is to be used to assess a resident's status upon the return from a dialysis visit. This requirement will be reviewed with them again when a dialysis resident is admitted once to the facility once again. Additionally, the DON and Administrator have been in-serviced by the Nurse Consultant regarding what information will be needed from dialysis providers on a routine basis before confirming them as providers for facility residents in the future.</p> <p>Resident #32's open skin area has healed. The nurses will be in-serviced on the need for notifying the physician of resident changes and conditions and their responsibility to transcribe the orders received and to make sure that they are on the Medication Administration Record (MAR) and the TAR. They will be told of the facility policy that all treatments must have a physician's order in place.</p> <p><u>1. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be</p>		

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	<p>cracked dried skin. The resident indicated she had came from the hospital with supplies and was using it herself. She indicated no one had treated her legs since she had been at the facility. During the observation, the DON attempted to tell the resident the facility needed to treat her skin, however the Resident argued with the DON about the issue. The resident was shown the physician's orders regarding her skin and a discussion indicated the resident would allow the treatment only twice a week but she felt like no one in the facility was "qualified." She indicated someone had helped her get her socks on yesterday. The resident at times would agree to have staff assist her but she reiterated no one had been helping her since she had been at the facility. The resident was also noted to have very long, dark colored toenails all all of her toes on both feet. The resident indicated there was no podiatrist available at the hospital. The resident indicated she would like to see a podiatrist while here. The DON indicated the resident had not allowed her to see her legs prior to the observation.</p> <p>2. The clinical record for Resident "D" was reviewed on 03/10/2016 at 10:54 A.M. Resident "D" was admitted to the facility on 11/06/15, and readmitted on 01/26/16, and discharged on 02/14/16.</p>		<p>affected by these practices. If any member of the IDT becomes aware of residents with skin areas that are not being addressed; bowel and bladder</p> <p>2.assessments that are not finalized; dialysis residents without documentation from the dialysis center or from the nurse on duty when the resident returns to the facility; lack of admission orders; or lack of physician notification of changes in the residents' condition, he/she will report the issue directly to the Administrator and DON, who will begin an investigation immediately to resolve the issue as quickly as possible. Once the resident is taken care of, the DON, Administrator, or other involved IDT member will re-train the staff</p> <p>3.involved in the issue. Progressive written counseling will be rendered as indicated by the situation.</p> <p><u>4.What measures will be put into place to ensure this practice does not recur?</u> If open areas, bruises, or other skin issues are identified, the nurse will assess each one with documentation of the area,including size and full description of each area. The physician is to be notified of any unusual skin issue and any orders that are received will be transcribed by the nurse receiving the orders, including documentation on the TAR for administration of treatments. An</p>		

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	<p>The resident's diagnoses on his 11/06/15 admission, included but were not limited to: Enterocolitis due to clostridium difficle, cerebral infarction, dementia without behavioral disturbance, muscle weakness, difficulty in walking, gastro-esophageal reflux, depressive disorder, anemia, dysphasia, diabetes mellitus, abnormal weight loss, macular degeneration, hypertension and hyperlipidemia.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 11/17/15, indicated the resident was moderately cognitively impaired, had no mood indicators, required extensive staff assistance of two staff for bed mobility, transfer needs, wheelchair locomotion, and toileting assistance and one person extensive assistance for dressing and personal hygiene. The resident only required supervision and set up help for eating needs. The resident was documented as having coughing and choking during swallowing medications and his weight was 141 pounds and had experienced significant weight loss and had one Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) pressure ulcer on admission.</p>		<p>emphasis will be placed on making sure that physician orders are put into the electronic medical records system and they each is followed through by all nurses to make sure that the residents are receiving what the physician has ordered. If the DON or other IDT member finds that an assessment has not been completed or followed up by staff as necessary, they will notify the DON (if she is not already aware) who will make sure that the assessment is done as quickly as possible, with the results followed through as needed and reflected on the resident's care plan. In all of these areas mentioned in the 2567, the DON and Administrator will make sure that any identified issue will be addressed as quickly as possible for the resident's health and safety. Once that is assured, the staff members involved in the issue itself will receive re-training and possible written counseling, depending on the situation itself.</p> <p><u>1. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> A medication review audit and the Care Plan Audit will be completed by the DON/designee 5 times a week for 30 days then twice a week for 30 days and then weekly ongoing. The DON or other designated members of the IDT will bring the result of their audits to the weekly Standards of Care</p>		

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	<p>The acute care center discharge orders for Resident "D" included an order for the antifungal medication, Metronidazole (a medication to treat the resident's clostridium difficle infection) 250 mg (milligram) tablets for 500 mg (2 tablets) by mouth every 8 hours. The Medication Administration Record for Resident "D" for November 2015, indicated he was only given Medronidazole 250 mg one tablet every 6 hours instead of the 500 mgs ordered.</p> <p>During an interview on 03/15/16 at 3:45 P.M., the Director of Nursing (DON) indicated a transcription error had been made for the Metrolmidazole dose. She indicated the discharge order from the acute care center indicated the resident was to receive Metrolmidazole 500 mg every 6 hours but instead the resident was given Metrolmidazole 250 mg every 6 hours. The DON indicated the facility policy and to have the next nurse working double check the orders transcribed for all new admissions. There was no documentation for this process so there was no way to tell if the orders had been double checked.</p> <p>Resident "D" had a gastrostomy tube placed to aid in his nutritional status on 12/31/15. On 01/12/16, Resident #15</p>		<p>meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the assigned member of the IDT and the results of those recommendations will be brought back to the next scheduled QA Committee meeting for review. When the written audits have shown 100% compliance, the QA Committee may decide to stop them; however, the monitoring by the IDT members will continue as indicated on an ongoing basis.</p>		

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	<p>was admitted to an acute care facility to treat and abdominal abscess and infection of the gastrostomy tube insertion site. He was readmitted to the facility on 01/26/16. The readmission orders included order for the resident to receive Zosyn 3.375 gm (grams)/50 ml (milliliters) per Intravenous line every 6 hours.</p> <p>The January 2016 Medication Administration Record for Resident "D" indicated he received the Zosyn antibiotic medication every 8 hours instead of every 6 hours, thus he missed one intended dose per 24 hours.</p> <p>During an interview on 03/15/16 at 3:45 P.M., the Director of Nursing, indicated there was a timing error for the Zosyn antibiotic which was ordered on the discharge orders from the acute care center on 01/26/16, and was to be given per intravenous route every 6 hours for 6 days but was only administered every 8 hours for 6 days.</p> <p>3. The clinical record for Resident #6 was reviewed on 03/11/2016 9:30:16 A.M. Resident #6 was admitted to the facility on 05/16/03, with diagnoses, including but not limited to: diabetes, cerebrovascular disease, hemiplegia, dysphagia, hypertension, atrial</p>			

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	<p>fibrillation, major depressive disorder single episode, enlarged prostate, hyperlipidemia and hypothyroidism. A diagnosis of pressure ulcer was added on 07/05/11.</p> <p>The most recent quarterly MDS (MInimum Data Set) assessment, completed on 01/15/16 indicated the resident had a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) pressure area with granulation which had been present since 02/11/15. The resident also required extensive staff assistance for transfers, toileting, and was occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>The care plans, current through 04/15/16, included the following interventions: *for bowel incontinence - to check the resident every two hours and assist with toileting as needed. *for the risk of skin breakdown - to provide incontinent care with each episode, pressure relieving cushion to my wheelchair, pressure relieving mattress on my bed, turn and reposition every 2 hours while in bed and as needed, and weekly skin assessment by charge nurse. *for the resident's refusal of care - a goal</p>			

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	<p>for the resident to agree to lay down after at least one meal daily to promote increased healing of the wound on his buttocks. The interventions included, but were not limited to: allow me to make decisions about my treatment regimen, educate me of possible outcomes of not complying with treatment of care, give clear explanations of all care activities, provide me with opportunities for choice during care provision and remind me of benefits/consequences of my decisions.</p> <p>Resident #6 was observed, on 03/11/16 at 8:37 A.M., seated in his wheelchair in the assisted dining room. He was propelled in his wheelchair by staff back to the hallway just outside his room at 9:07 AM. He was then observed at 9:15 AM seated in the back hallway by his room door in his wheelchair. He indicated his wheelchair was newer but was not comfortable as the seat was too short. The resident's stomach protruded in his front and it was hard to determine if the wheelchair fit him properly. The resident's body obscured visualization of any wheelchair pad but he indicated he had all kinds of pads in the wheelchair seat.</p> <p>Resident #6 remained in his wheelchair sleeping, at times snoring from 9:14 A.M. to 11:53 A.M. when LPN (Licensed</p>			

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	<p>Practical Nurse) #50 took his blood sugar in the hallway. LPN #50 informed the resident he needed some insulin and she administered the insulin to the resident in the hallway because the resident did not want to go into his room. The resident remained in his wheelchair beside his room door until 12:08 P.M., when a CNA (Certified Nursing Assistant) took him down the hallway towards the dining room. She did not offer to toilet the resident or assist him to move in his wheelchair. The staff member pushed his approximately 1/2 way down the hallway and the resident was then observed to slowly propel himself in his wheelchair directly into the assisted dining room.</p> <p>The resident remained in his wheelchair at the table eating his meal and was still in the dining room at 1:15 P.M.</p> <p>At 1:26 P.M., CNA #56 pushed Resident #6 from the dining room straight to the back hallway just outside his room door and turned the resident's wheelchair so he faced the hallway. She did not ask him to move or offer to toilet the resident but she did give the resident a hug when he requested a hug. The resident remained in his wheelchair with no position change or any care offering by staff until 2:05 P.M. when he rang a bell and informed CNA #52 he needed to go to the</p>			

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	<p>bathroom. She informed him she needed to go get some help and she would be back to assist him.</p> <p>On 03/11/16 at 2:27 P.M. Resident #6 was assisted with two nursing assistants to stand, pivot and sit on the toilet. After the resident used the bathroom, the resident's open area was observed with LPN #57. The resident's buttocks and scrotum were very discolored and pendulous. There was a covered, silver dollar sized open area with frank blood dripping from the wound noted on what appeared to be below the resident's buttocks area. LPN #57 indicated the dressing was usually changed by night shift so she was not aware of the status of the wound. There was a moderate to large amount of sanguineous drainage noted on the removed dressing. The edges of the wound, approximately soft ball sized was dark purple in color. The nurse then cut a silver dollar sized piece of the ordered alginate dressing and placed an absorbent dressing over the whole wound. The absorbent dressing was very large and did not adhere to the resident's skin. The nurse indicated she thought the open wound was on the resident's scrotum. There were several bloody thin elongated areas approximately 1/4 inch by 2 inches long on the other side of the resident's</p>			

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	<p>scrotum.</p> <p>The resident was not given an opportunity to toilet, offload his weight, or lay down in his bed from 8:35 A.M. through 2:27 P.M.</p> <p>4. During the initial tour, on 3/7/16 at 9:50 A.M., Resident #47's indwelling Foley catheter was observed from the hallway.</p> <p>On 3/9/16 a 9:22 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was admitted on 2/26/16 and re-admission on 3/4/16. The resident's diagnoses included but was not limited to: adult failure to thrive, chronic obstructive pulmonary disease, insulin dependent diabetic-uncontrolled, chronic embolism/thrombosis of deep veins of lower extremity (bilateral), viral hepatitis and congestive heart failure.</p> <p>The hospital discharge orders-plan of care, dated 3/4/16, found in a large manila envelope in the resident's chart indicated "...Begin taking these medications at these doses following discharge...lactated ringers intravenous solution 70 ml/hr [milliliters per hour] megestrol (Megace) 400 mg/10 ml [milligrams/milliliter] 400 mg Oral</p>			

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	<p>Daily...." Another form titled "ORDERS TO BE FOLLOWED," dated 3/4/16, indicated the following</p> <p>"...Flush/Maintain PICC [Peripherally Inserted Central Catheter] per protocol...."</p> <p>The only care plans for Resident #47, initiated on 3/2/16, indicated the resident did not wish to attend any activities and wished to have supervised smoking privileges. There were no other care plans documented on the electronic chart.</p> <p>A nursing progress note, dated 03/05/16 at 2:10 P.M. indicated the nurse practioner wanted to hold the intravenous fluids until further clarification. There was no physician's order written regarding the withholding of the medication. There was also no documentation of any care of the resident's PICC line to ensure patency of the line.</p> <p>During an interview, on 3/9/16 at 11:15 A.M., the Director of Nursing (DON) indicated she was unable to explain why the resident's admission orders were not clarified, discontinued, initiated or resumed as ordered. She indicated the Foley catheter was still in place as the nurses were tracking the resident's input and output. She indicated there were no</p>			

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	<p>other care plans for the resident at this time.</p> <p>On 3/9/16 at 12:30 P.M., the Nurse Consultant provided a policy titled "Physician Orders - Monthly Recap", revised on 1/2013, and indicated the policy was the one currently used by the facility. The policy did not indicate a procedure for admission orders from a hospital.</p> <p>5. The clinical record for Resident #31 was reviewed on 3/9/16 at 10:15 A.M. Resident #31 was admitted to the facility, on 2/6/12, with diagnoses, including but not limited to : Alzheimer's disease, adult failure to thrive, diabetes mellitus type II and osteoarthritis of the hip.</p> <p>A Braden Scale for predicting pressure sore risk, dated 1/4/16, indicated the resident was at high risk for developing pressure ulcers related to the degree to which skin is exposed to moisture: very moist skin is often, but not always moist. The resident is bedfast and very limited related to mobility.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 1/5/16, indicated the resident was severely cognitively impaired, required total dependence two plus person assist with transfers and toilet use and extensive two</p>			

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	<p>person physical assist for bed mobility. The resident was documented as always incontinent of her bladder. A bowel and bladder assessment could not be located on the paper or electronic charting for Resident #31.</p> <p>A care plan, dated 1/7/16, indicated the resident was incontinent of both bowel and bladder due to Alzheimer's disease. The interventions included, but were not limited to: I am to be cleansed and dried after each incontinent episode. I require staff to check and change me every two hours and as needed. I want to wear a brief to maintain my dignity. I will have a bowel and bladder assessment completed upon admission/readmission, quarterly, annually, with significant changes and as needed.</p> <p>A Certified Nursing Assistant (CNA) worksheet, undated, indicated Resident #31 required a 2 person hooyer (lift device) transfer, wears briefs due to bowel and bladder incontinence, was to be checked and changed, and was total assist with all activities of daily living (ADL).</p> <p>On 3/9/16 from 8:05 A.M. to 9:03 A.M., Resident #31 was observed seated in her Broda (reclining wheelchair) chair in the assisted dining room, the staff was</p>			

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	<p>feeding the resident her breakfast. At 9:04 A.M., the resident was taken by staff from the assisted dining room and placed in the hallway outside of her room. At 9:10 A.M., the resident was taken in her Broda chair by the Activity Director for a walk in the hallway. At 9:15 A.M., the Activity Director brought the resident back to her room and placed the resident in the hallway outside of her room where she remained until 10:22 A.M. when the Activity Director assisted the resident in her Broda chair to the dining room for an activity. At 11:09 A.M. the resident was assisted by the Activity Director from the main dining room into the assisted dining room. The resident remained in the assisted dining room until 1:15 P.M. At 1:15 P.M., the resident was propelled in her Broda chair by a CNA and placed in the hallway outside of her room. From 1:15 P.M. to 3:15 P.M., the resident remained outside of her room in the hallway seated in her Broda chair. At no time was the resident observed to be checked or changed. At 3:20 P.M., CNA #25 was questioned if the resident ever lays down in the afternoon the CNA indicated "sometimes." At 3:25 P.M., CNA#25 and CNA#26 assisted Resident #31 into bed with the use of the hoyer lift. As the resident was lifted from her Broda chair there was a strong foul smelling urine odor, the pressure</p>			
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	<p>relieving cushion in the Broda chair was wet, the resident's light tan slacks had a large wet stain on the back of them. The brief was saturated with a strong foul smelling urine odor, the resident had a moderate amount of soft brown bowel movement in the brief. A Mepilex dressing to the coccyx area was wet with urine and the dressing was coming off of the coccyx area. LPN #27 came into the room to remove the soiled dressing to the coccyx and apply a new dressing. LPN #27 indicated the resident had a pressure area on her coccyx but it was healed now the dressing continues to the area for protection. The skin to the coccyx was observed no open areas was observed.</p> <p>During an interview, on 3/9/16 at 3:30 P.M., CNA #26 indicated she works the evening shift and receives report from the day shift before they leave for the day. She indicated the resident should have been changed before and after lunch because she is a check and change every 2 hours and as needed.</p> <p>On 3/10/16 at 10:00 A.M., RN (Registered Nurse) #20 provided a policy titled "Bladder Incontinence Program," dated 5/2006, and indicated the policy was the one currently used by the facility. The policy indicated "...Bladder Assessment...4. Once the form is</p>			

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	<p>completed, the MDS Coordinator will add the appropriate bladder program to the resident's plan of care, nursing assistant assignment sheets, and other relevant documents, such as ADL sheets, restorative nursing forms, & 24 hour report form to assure staff knowledge and follow through...5...Reassessment will occur at least quarterly after that, as indicated by the resident's condition and the outcome of the bladder program...."</p> <p>During an interview, on 3/14/16 at 10:44 A.M., the Director of Nursing indicated the resident should be checked and changed after each meal, at HS (bed time) and as needed. She further indicated she was unsure why a bladder assessment had not been completed on this resident. She indicated the MDS nurse should have completed it to correlate with the 1/5/16 MDS assessment. She indicated the quarterly update should be on the back of the bladder assessment and the assessment should be on the paper chart.</p> <p>6. Resident "F's" record was reviewed on 3/9/16 at 10:42 A.M., and indicated the resident was admitted to the facility on 2/13/14, with diagnoses, including but not limited to, dementia without behavioral disturbance, enlarged prostate, syncope, convulsions, muscle weakness</p>			

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	<p>and psychotic disorder with hallucinations.</p> <p>The annual MDS(Minimum Data Set) assessment, completed on 12/8/15, indicated the resident is frequently incontinent, is on a urinary toileting program, requires extensive 1 person assist for dressing and personal hygiene, limited 1 person assist for transfers and toileting and total dependence for bathing. The BIMS (Brief Interview for Mental Status) score was 4 indicating the resident has severe dementia.</p> <p>A Bladder Assessment Form, dated 12/8/15, indicated the resident is currently incontinent of bladder and a 5 day voiding pattern would start on 12/12/15 at 6:00 A.M. The Director of Nursing was unable to locate the 5 day voiding pattern form. The DON indicated the form should be on the paper chart.</p> <p>A care plan, dated 12/11/15, indicated the resident was frequently incontinent of his bladder and required a restorative toileting program to decrease his incontinent episodes. The interventions included, but were not limited to: staff prompting him to void and assist him to the bathroom every 2 hours.</p> <p>A care plan, dated 12/16/15, indicated the</p>			

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	<p>resident required staff assistance with completing his daily care/activities related to his impaired mobility and that he required assistance with transfers, bed mobility, toileting, dressing, personal hygiene and bathing due to his diagnosis of dementia, lack of coordination and muscle weakness. The interventions included, but were not limited to: he was to receive assistance with showers, toilet use, transfers and incontinence care with each episode. The resident was to receive assistance with oral care twice daily, assistance with picking out his clothes daily and set up of his personal hygiene items.</p> <p>A Certified Nursing Assistant (CNA) assignment sheet, undated, indicated Resident "F" required 1 assist for all ADL's (Activities of Daily Living), dressing and grooming and to assist with toileting. There was no information on the CNA assignment sheet indicating the resident was on a restorative toileting plan.</p> <p>On 3/9/16 at 9:01 A.M., Resident "F" was observed in the assisted dining room, he was wearing a gray hooded sweatshirt and a blue pair of sweat pants. His eyes were matted, his face was unshaven and his fingernails were long and a dried brown substance was observed under the</p>			

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	<p>nails. At 9:10 A.M., the resident propelled himself in his wheelchair to the hallway outside of his room, he had a full bottle of orange soda in his hands. While sitting in his wheelchair he fell asleep the soda fell out of his hands spilling a small amount of soda onto his sweat pants and onto the carpeted floor in the hallway. At 9:42 A.M., the resident propelled his wheelchair into his room where he was observed to transfer himself to his bed. From 10:30 A.M. to 12:00 P.M., the resident rested in his bed, he was not observed during this time to take himself to the bathroom nor was staff observed to enter his room and offer to take him to the restroom. At 12:05 P.M., CNA #22 entered the residents room and indicated to the resident it was time for lunch. CNA #22 was observed to transfer the resident from his bed to his wheelchair and then propel him to the dining room. CNA #22 was not observed to assist the resident to the restroom.</p> <p>An ADL form, dated March 2016, indicated Restorative Toileting: Assist me to the bathroom between 8-8:30 A.M., 9:30-10 A.M., 1-1:30 P.M., 3:30-4 P.M., 6-6:30 P.M. and just before I go to bed with one staff assist. On 3/9/16, during the day shift there was only one time documented that the resident was assisted to the bathroom at 1:59 P.M.</p>			

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	<p>On 3/10/16 at 8:45 A.M., Resident "F" was observed in his wheelchair in the assisted dining room, he was wearing the same gray hooded sweatshirt and a blue pair of sweat pants. His eyes were matted, his face unshaved and his fingernails were long with a brown substance observed under the nails. At 9:00 A.M., the resident propelled his wheelchair from the dining room to his room and transfers himself back to bed. From 10:00 A.M. to 12:00 P.M., the resident was observed resting in his bed. The resident was not observed during this time to take himself to the bathroom, nor was staff observed to enter his room and assist him to the bathroom. At 12:05 P.M., CNA # 22 transferred the resident from his bed to his wheelchair and then propelled him to the dining room she did not assist him to the restroom prior to the meal.</p> <p>During an interview, on 3/10/16 at 12:07 P.M., CNA #22 indicated the resident requires a 1 person assist for transfers. She further indicated the resident receives showers on the evening shift at least 3 times per week which would include shaving him and performing nail care at that time. She indicated the resident is incontinent and wears a brief, she was not aware the resident was on</p>			

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	<p>any kind of toileting program.</p> <p>On 3/10/16 at 4:00 P.M., RN #20 provided a policy titled "Bath-Bed, Partial, Shower, Tub," dated June 2004, and indicated the policy was the one currently used by the facility. The policy indicated "...Bed Bath Procedure:...16. Care of fingernails and toenails is part of the bath. Be certain nails are clean. If toenails would be difficult to care for, inform the nurse that the resident needs to see the podiatrist...."</p> <p>During an interview, on 3/15/16 at 3:17 P.M., the Administrator indicated the facility has a guardian angel program in place and that all of the residents have a guardian angel. If the residents guardian angel observes a concern with personal hygiene including nail care they would let the nursing staff know the residents nails needed to be trimmed ad cleaned.</p> <p>7. A clinical record review was completed on 3/9/2016 at 12:25 P.M., for Resident #11. Resident #11 was admitted on 2/8/2016. The diagnoses included, but were not limited to: kidney failure, secondary hypertension and peripheral vascular disease.</p> <p>A care plan, dated 2/19/2016, indicated "...Ask the dialysis center to send</p>			

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	<p>documentation back to the facility, with me, of anything that they have done for me during my dialysis visit..." and "...Nursing to complete my post dialysis assessment after I return from dialysis...."</p> <p>During a record review on 3/9/2016 at 2:45 P.M., the DON (Director of Nursing) indicated the facility does not have any documentation related to communication with the dialysis center and unable to locate any orders to monitor the residents dialysis access site.</p> <p>A physicians order indicated Resident #11 was to receive dialysis three times a week on Monday, Wednesday, and Friday.</p> <p>There was no documentation related to a dialysis assessment for Resident #11.</p> <p>During an interview on 3/10/2016 at 10:45 A.M., LPN #2 indicated the facility did not have a form of communication related to dialysis services or assessments for Resident #11. She further indicated that there was no form of documentation she could access at the facility to inform her of the assessments performed at the dialysis center for Resident #11.</p> <p>On 3/7/2016 at 2:00 P.M., the DON provided a dialysis contract titled " SNF</p>			

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	<p>[Skilled Nursing Facility] OUTPATIENT DIALYSIS SERVICES AGREEMENT," dated July 1, 2013, and indicated this was the contract used for Resident #11. The contract indicated "...D. Mutual Obligations 1. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and ESRD [End Stage Renal Disease] Dialysis Unit. Documentation shall include, but not be limited to, participation in care conferences, continual quality improvements program, annual review of infection control of policies and procedures, and the signatures of team members from both parties on a Short Term Care Plan (STCP) and Long Term Care Plan (LTCP). Team members shall include the physician, nurse, social worker and dietitian from the ESRD Dialysis Unit and a representative from the Nursing Facility. The ESRD Dialysis Unit shall keep the original the STCP and LTCP in the medical record of the ESRD Resident and the Nursing Facility shall maintain a copy...."</p> <p>On 3/10/2016 at 11:15 A.M., the Coporate Nurse provided a policy titled "Hemodialysis," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated</p>			

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	<p>"...GUIDELINES: The Dialysis Unit should provide a written progress note of some type regarding the pertinent issues that were observed or occurred during the dialysis visit. It should also include the amount of fluids that the resident consumed during his/her visit...." and "...6. Assess resident upon return from dialysis and document findings on Post Dialysis Assessment form. If there are additional observations, the nurse will document them in the residents's chart...." and "...Document resident's status on the Post Dialysis Assessment form when returning from dialysis...."</p> <p>8. A clinical record review was completed on 3/9/2016 at 12:25 P.M., for Resident #11. Resident #11 was admitted on 2/8/2016. The diagnoses included, but were not limited to: kidney failure, aphasia, dysphasia, muscle weakness, difficulty in walking, arthropathy, constipation, arterosclerotic heart disease of native coronary artery without angina pectoris, gastritis without bleeding, secondary hypertension and peripheral vascular disease.</p> <p>A care plan, dated 2/19/2016, indicated "...Observe my feet with baths and weekly skin assessments to ensure no other issues are occurring...." and Make my physician and family aware of any</p>			

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	<p>changes/worsening to my skin condition...."</p> <p>A care plan, dated 2/25/2016, indicated "...My skin condition will be monitored at least twice a week by the CNA (Certified Nursing Assistant) during my shower and weekly by the charge nurse...."</p> <p>A care plan, dated 2/25/2016, indicated "...My skin condition will be monitored at least twice a week by the CNA during my shower and weekly by the charge nurse...."</p> <p>A CNA documentation report indicated Resident #11 had not received a shower from March 2 thru March 9, 2016.</p> <p>During an interview on 3/10/2016 at 9:44 A.M., the Corporate Nurse indicated there was no documentation for Resident #11 receiving showers at the facility. She further indicated that there was no documentation of a complete skin assessment completed on Resident #11.</p> <p>On 3/10/2016 at 10:00 A.M., the Coporate Nurse provided the policy titled "Care Planning," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated "...PURPOSE: To identify problems and developmental solutions for the</p>			

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	<p>coordination of resident care...."</p> <p>9. A clinical record review was completed on 3/10/2016 at 8:45 A.M., for Resident #32 and indicated he was admitted on 8/28/2015. The clinical record indicated diagnoses included but were not limited to: Pneumonia unspecified organism, complete traumatic amputation of one unspecified lesser toe, initial encounter, muscle wasting and atrophy not elsewhere classified unspecified site, atrial fibrillation, encounter for other orthopedic after care, gastro-esophageal reflux disease without esophagitis, muscle weakness, dysphasia oropharyngeal phase, non-st elevation (nSTEMI) myocardial infarction, heart failure, pressure ulcer of unspecified site, atresia of esophagus with tracheo-esophageal fistula, encounter for other specified after care, dementia, behavioral disturbance, acquired absence of unspecified great toe, presence of cardiac pacemaker, gangrene, anemia, colostomy, hypertension, type 2 diabetes mellitus, and other specified diabetes mellitus with other skin complications.</p> <p>A care plan, dated 1/28/2016 at 8:59 A.M., indicated "...I need any changes in my skin to be reported to the MD [Medical Doctor] immediately...."</p>			

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	<p>A weekly summary, dated 2/12/2016, indicated Resident #32 had no new skin issues.</p> <p>A weekly summary - licensed nurse, dated 3/1/2016, indicated Resident #32 had no new skin issues.</p> <p>A form titled "ASSESSMENT OF OTHER SKIN ABNORMALITIES," dated 3/10/2016, indicated Resident #32 had an area to his left outer arm 8 cm (centimeters) x 6 cm and red in color. The form indicated "...Area red. First layer of skin gone. No s/s [signs or symptoms] of infection. Denies pain Refused measurements. Dressing applied...." The form further indicated there was a new order for Mepilex (a type of dressing) to be changed every three days.</p> <p>On 3/9/2016 at 3:00 P.M., Resident #32 was observed to have an open area to his left arm. The area was located on the underside of his forearm. Resident #32 was observed multiple times leaning in his wheelchair putting pressure on his left arm for extended periods of time.</p> <p>On 3/10/2016 at 8:49 A.M., Resident #32 was observed to have a bandage on his left arm. The bandage was observed to be loose and falling off. Drainage was</p>			

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	<p>observed to the outside of the bandage.</p> <p>On 3/15/2016 at 10:28 A.M., Resident #32s' bandage to his left arm was observed to be dated 3/9/2016.</p> <p>During an interview on 3/10/2016 at 10:28 A.M., the Corporate Nurse indicated there was no documentation on the area found yesterday to the Resident #32s' left arm. She further indicated that there was no documentation indicated the physician had been contacted.</p> <p>During an interview on 3/10/2016 at 10:55 A.M., the DON indicated there was no documentation of an assessment completed on Resident #32s' left arm nor was there any documentation of contacting the physician.</p> <p>During an interview on 3/15/2016 at 10:32 A.M., the DON indicated that the dressing was placed on 3/9/2016, and should have been changed on 3/12/2016. She further indicated the dressing order was to change the residents dressing every three days.</p> <p>On 3/10/2016 at 10:00 A.M., the Coporate Nurse proviided the policy titled "Dressing Change, Clean and Sterile," dated June 2004, and indicated this was the policy currently used by the</p>			

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F 0309 SS=J Bldg. 00	<p>facility. The policy indicated "...PURPOSE: To protect open wound from contamination. To prevent irritation. To prevent infection and spread of infection. To absorb and contain drainage..."</p> <p>On 3/14/2016 at 11:36 A.M., the Coporate Nurse provided the policy titled "Change of Condition - ICF/MR [Intermediate Care Facility/Mentally Retarded]," dated March 9,2005, and indicated this was the policy currently used by the facility. The policy indicated "...Documentation in the nurses' notes is required each shift on any resident who experiences a problem, demonstrates a symptom or any change of status. Documentation must continue each shift for at least 24 hours, and usually 72 hours, after the problem is identified, then daily until the problem is noted as resolved...."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p>				

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	<p>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>A. Based on observation, record review and interview, the facility failed to provide care and services related to diabetic monitoring for a resident who exhibited high and low blood sugar readings at the facility resulting in a change of consciousness and hospitalization. The facility failed to ensure physician orders for a readmission to the facility were followed timely for intravenous fluids for hydration and care of a PICC (Peripherally Inserted Central Catheter) line physician clarification was obtained for the use of a Foley catheter for 1 of 7 residents reviewed for physician orders. (Resident #47) The facility failed to ensure diabetes and blood glucose monitoring was initiated timely for 1 of 10 residents with diabetes. (Resident #47)</p> <p>The Immediate Jeopardy began on 02/26/16 when Resident #47 was initially admitted to the facility with diagnoses including diabetes and medication orders for insulin, and no plan was implemented to ensure his blood glucose level was at a safe level prior to insulin administration. This deficient practice resulted in a hospitalization due to hypoglycemia</p>	F 0309	<p>It is the policy of this facility that all directives/orders given by the attending physicians and/or their nurse extenders for the purpose of treating and directing the care of the residents of this facility will be transcribed by a licensed nurse and completed as ordered, such as intravenous fluids, care of PICC lines, and the use of Foley catheters.</p> <p>It is the policy of this facility that each resident who is admitted or readmitted to the facility will have a Nursing Admission Screening/History completed by the charge nurse, and that assessment will be documented in the clinical record. The facility will ensure that admission/readmission orders are implemented accurately. It is also the policy of this facility to ask for physician orders for blood glucose meter testing of all diabetic residents, as well as parameters to indicate when sliding scale insulin coverage is needed or guidelines for physician notification. These orders will be transcribed by a licensed nurse and completed as ordered. In addition, the facility will ensure that insulin is administered timely when given prior to the resident's meal.</p> <p><u>1. What corrective action will be done by the facility?</u> A. Upon notification of the IJ deficiency, the Director of Nursing</p>	04/15/2016

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	<p>(decreased blood glucose levels) for Resident #47. The Immediate Jeopardy continued as physician orders regarding intravenous fluids and care of a PICC line were not initiated timely. The Administrator and Director of Nursing were notified of the Immediate Jeopardy at 1:07 P.M. on 03/09/16. The Immediate Jeopardy was removed on 03/15/16 at 2:35 P.M., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>B. Based on observation, record review and interviews the facility failed to ensure admission orders were implemented accurately for 4 of 6 residents in an expanded sample. (Resident #45, #46, #49, and "D") In addition, the facility failed to ensure insulin was administered timely for 2 of residents observed during a medication administration observation. The facility failed to ensure a system was in place to communicate with a dialysis center and complete post dialysis assessments for 1 of 1 residents reviewed regarding dialysis. The facility also failed to ensure impaired skin was assessed timely and thoroughly for 4 of 6 residents reviewed due to impaired skin or pressure</p>		<p>contacted the Nurse Practitioner who was involved in the readmission orders when resident #47 returned from the ER on 3/4/16. The Nurse Practitioner confirmed that she did not want the Lactated Ringers or the Megace to be given to the resident upon his readmission, because of the concern that they might exacerbate the resident's diarrhea, even though the nurse on duty at that time did not write specific orders to discontinue or hold those 2 items.</p> <p>After speaking with the Nurse Practitioner, orders were written on 3/9/16 to discontinue the Megace (which the resident has not had since his readmission on 3/4/16) and the Lactated Ringers. The Nurse Practitioner discontinued the resident's PICC line on 3/9/16, effectively removing the possibility of administration of the Lactated Ringers solution.</p> <p>On 3/9/16 orders were also received for accurate glucose monitoring 4 times a day and parameters for sliding scale insulin coverage for resident #47. Resident #47 and Resident #45 are no longer at this facility.</p> <p>B. 1 The area noted on Resident B's forearm has healed. In addition to the information for staff-service above, the staff will also be trained on documentation</p>		

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	<p>ulcers. (Resident "B," #49, #11 and #47)</p> <p>Findings include:</p> <p>A. During the initial tour, on 3/7/16 at 9:50 A.M., Resident #47's indwelling Foley was observed from the hallway. The Foley catheter was not in a dignity bag and was observed on the floor, slightly under the resident's bed.</p> <p>On 3/9/16 a 9:22 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was initially admitted on 2/26/16 from the hospital. On 2/28/16 at 8:30 P.M., the resident was found unresponsive and sent to the Emergency Room (ER). He was released from the ER and returned to the facility on 2/29/16 at 3:15 P.M. On 3/2/16 at 12:54 P.M., the resident was again found unresponsive and sent to the ER. He was admitted to the hospital at that time. He was readmitted to the facility on 3/4/16 at 9:30 P.M.</p> <p>Resident 47's diagnoses, included but were not limited to: adult failure to thrive, chronic obstructive pulmonary disease, insulin dependent diabetic-uncontrolled, chronic embolism/thrombosis of deep veins of lower extremity (bilateral), viral hepatitis</p>				<p>ofconversations with providers who work with the residents outside of thefacility; use of the bruise investigation form for documentation of anyidentified bruises or discolorations observed on residents.</p> <p>B. 2 The DON and Nurse Consultant willre-train all nurses to make sure that residents, including Resident #6, havethe assistive devices needed to eat or drink, and that residents who are slowto respond during meal time, especially those who are diabetic, will be checkedby the nurse and will be offered assistance to eat or drink, so that he/she canconsume the meal.</p> <p>B. 3 When notified of the issuewith timing of insulin administration and meal service to those residents whoreceive fast acting insulin, the facility immediately changed their practiceand made sure that residents receiving insulin were also given sugar freepudding to eat before being taken to the dining room for their breakfast. All nurses were in-serviced at thattime by the DON to offer sugar free pudding to all residents receiving fastacting insulin before being taken to the dining room for breakfast. Inaddition, the DON and Nurse Consultant will re-train all nurses in thatpractice once again, as well as making sure that residents have the assistivedevices needed to eat or drink, and that residents who</p>		

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	<p>and congestive heart failure.</p> <p>A hospital History & Physical (H and P), dated 2/26/16, indicated the resident had presented to the ER with complaints of lower extremity swelling and ulcerations of his lower extremities, increased falls poorly controlled diabetic and generalized weakness. The H&P indicated the resident was noncompliant with medications and diet. The resident's glucose upon admission (to the acute care facility) was 687 and he had a poor nutritional status. The H&P indicated the resident had a decubitus ulcer on his buttock, multiple abrasions on his lower extremities, some of the areas were open/weeping and others were scabbed. He also had pedal swelling and multiple abrasions on his forearms.</p> <p>A Nursing Progress note, dated 2/28/16 at 20:30 (8:30 P.M.), indicated a CNA (Certified Nursing Assistant) had entered the Resident #47's room and found him unresponsive. The resident was sent to a local ER.</p> <p>An Emergency Department Chart, dated 2/28/16, indicated the resident was seen in the ER with transient altered mental status, anemia, and congestive heart failure. There was no documentation there was a blood sugar blood test taken</p>		<p>are slow to respond during meal time, especially those who are diabetic, will be checked by the nurse and will be offered assistance to eat or drink, so that he/she can consume the meal.</p> <p>B. 5 Resident #46 has gone home; however, the DON and Nurse Consultant have in-serviced the nurses on the need for completing orders as received from the physician, including transcribing them on the MAR or TAR and making sure that documentation of administration is complete and current for each resident.</p> <p>B. 6 The treatment orders for Resident #49 have been transcribed properly and are being administered and documented as ordered. The resident's care plan has been updated to reflect the treatments that she is receiving. The status of the skin condition on her body is assessed and documented weekly. The facility is making arrangements for Resident #49 to be seen by a podiatrist, as per her request.</p> <p>B. 7 Resident D is no longer a resident of this facility. The licensed nurses will be in-serviced on the appropriate transcription of physician orders for medications, so that they can be given as directed by the physician by 4/15/16.</p> <p>B. 8 Resident #11 is no longer at</p>				

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	<p>in the ER.</p> <p>A Nursing Progress note, dated 3/2/16 at 12:54 P.M., indicated Resident #47 was again found unresponsive and his blood sugar was assessed and was 67. The Nurse Practitioner was notified and an order for transport to local ER was received. The nursing note indicated Resident #47's blood sugar quickly dropped to 27 prior to his transfer to the emergency room.</p> <p>The only care plans for Resident #47, initiated on 3/2/16, indicated the resident did not wish to attend any activities and wished to have supervised smoking privileges. There were no other care plans documented on the electronic chart</p> <p>A Nursing Progress note, dated 03/05/16 at 2:10 A.M., the resident returned from the hospital with a Foley catheter and a PICC line in place. This progress note indicated the nurse practitioner wanted to hold the intravenous fluids until further clarification. There was no physician's order written regarding the withholding of the medication. There was also no documentation of any care of the resident's PICC line to ensure patency of the line.</p> <p>A Nursing Note, dated 3/8/16, completed</p>		<p>thefacility and there are no other residents requiring dialysis at this time.However, the nurses will be in-serviced in the use of the post-dialysisdocumentation form, which is to be used to assess a resident's status upon thereturn from a dialysis visit. This requirement will be reviewed with them againwhen a dialysis resident is admitted once to the facility once again.Additionally, the DON and Administrator have been in-serviced by the NurseConsultant regarding what information will be needed from dialysis providers ona routine basis before confirming them as providers for facility residents inthe future.</p> <p><u>1.How will the facility identify otherresidents having the potential to be affected by the same practice and whatcorrective action will be taken?</u></p> <p>A.All residents who are admitted orreadmitted to this facility with physician orders and all diabetic residentshave the ability to be affected by this practice. Each resident who has beenadmitted since 2/26/16 has been checked to make sure that an admission nursingassessment has been performed, completed, and documented for each.</p> <p>All diabeticresidents have been checked by the Director of Nursing and Nurse Consultant tomake sure that they have current orders regarding blood glucose testing</p>	

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	<p>by the Nurse Practitioner, indicated the resident was refusing care, refusing blood sugar tests and refusing any care including hygiene.</p> <p>On 3/9/16 during the survey process, hospital discharge orders, dated 3/4/16, were found in a large manilla envelope in the chart. The orders indicated "...Begin taking these medications at these doses following discharge...lactated ringers intravenous solution 70 ml/hr [milliliters per hour]megestrol [Megace, an antioeplastics] 400 mg/10 ml [milligrams/milliliter] 400 mg Oral Daily...." Another form titled "ORDERS TO BE FOLLOWED," dated 3/4/16, indicated the following "...Flush/Maintain PICC per protocol...."</p> <p>Review of the Medication Administration Record for February and March 2016 indicated the resident had been administered Levemir (insulin) 10 units in the evening and 20 units twice a day subcutaneously during the day. The insulin orders were changed to Levemir 10 units in the evening and Novolog (insulin) 2 units with meals on his readmission back to the facility on 03/04/16. There was no plan or documentation of any routine assessments of his blood glucose levels in the chart.</p>		<p>andparameters for sliding scale coverage and/or physician notification. No otherissues have been identified. The Nurse Consultant and Director of Nursing willexamine the charts of current residents admitted or readmitted since 2/26/16 tomake sure that their orders are in place and being followed as written. If the DON or other member of the IDT observesany resident who is drowsy or having some difficulty in eating, he/she willnotify the charge nurse, so that the resident may be assessed and assisted asneeded.</p> <p>In the future,if any member of the IDT (Interdisciplinary Team) finds a resident who does nothave a complete nursing admission or readmission assessment, accuratelytranscribed written orders, or a diabetic resident that does not have ordersfor ongoing monitoring of his/her blood glucose, the Director of Nursing willbe notified immediately (if she is not already aware) of the issue. She willcontact the physician or nurse practitioner to confirm the resident's orders,including any diabetic monitoring that might be needed.</p> <p>In the instancewhere there is a lack of a completed admission/readmission assessment, she willmake sure that one is done and documented at that time. If anything unusual orabnormal is noted that was not documented</p>		

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	<p>During an interview, on 3/9/16 at 11:15 A.M., the Director of Nursing (DON) indicated she was unaware of any order for glucose monitoring or the use of a urinary catheter for Resident #47. She indicated she had checked the resident's blood sugar yesterday. She indicated the Lactated Ringer intravenous fluid and Megace medication, ordered on 03/04/16 was "on hold." She indicated the Nurse Practitioner had examined the resident on 03/05/16 and at that time she had put the fluids on hold pending "clarification."</p> <p>The Director of Nursing indicated the Nurse Practitioner had seen the resident again on 03/08/16, and was "checking with the physician" regarding the 3/4/16 orders for IV fluids and Megace. She was unable to explain why the resident's admission orders were not clarified, discontinued, initiated or resumed as ordered. She indicated the Foley catheter was still in place as the nurses were tracking the resident's input and output. She indicated there were no other care plans for the resident at this time.</p> <p>An untitled form, dated March 2016, indicated the start date for the documentation of the resident's input and output was 3/8/16. The form indicated the resident had 400 ml of catheter output</p>		<p>prior to the assessment, the DON will make sure that the physician or nurse practitioner is notified of that finding.</p> <p>B. All residents have the potential to be affected by these practices.</p> <p>If any member of the IDT becomes aware of residents with skin areas that are not being addressed; residents who are slow to eat or respond at meal time, or with assistive devices not available to them; residents who receive fast acting insulin without pudding being offered before meal service; receiving and not transcribing orders appropriately or lack of documentation of administration on the MAR and TAR; lack of skin assessments on a weekly basis; or dialysis residents without documentation from the dialysis center or from the nurse on duty when the resident returns to the facility, he/she will report the issue directly to the Administrator and DON, if she is not already aware.</p> <p>Once the resident situation is taken care of, the DON, Administrator, or other involved IDT member will re-train the staff involved in the issue. Progressive written counseling will be rendered for continued noncompliance.</p>		

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	<p>for the 11 to 7 night shift. There were no other output documentation notes from 3/4/16 thru 3/8/16.</p> <p>On 3/9/16 at 12:30 P.M. the Nurse Consultant provided a policy titled "Physician Orders - Monthly Recap," revised on 1/2013, and indicated the policy was the one currently used by the facility. The policy did not indicate a procedure for admission orders from a hospital. Another current policy received from the Nurse Consultant titled Admission Assessment - Nurse," dated June 2004, indicated "...21. Address resident problems and needs identified during assessment on "Initial Care Plan" form"</p> <p>During an interview, on 3/9/16 at 3:31 P.M., the Nurse Consultant indicated there was no policy or procedure regarding admission orders.</p> <p>During another interview, on 3/9/16 at 4:36 P.M., the Nurse Consultant indicated since the facility had gone to electronic charting regarding care plans and the initial care plan form was no longer being utilized by the facility. She indicated the facility had 21 days to develop a care plan for the resident.</p> <p>During an interview, on 3/10/16 at 3:39</p>		<p><u>1.What measures will be put into place to ensure this practice does not recur?</u></p> <p>A.All licensednurses will be educated by the Director of Nursing and/or the Nurse Consultanton the accurate and timely completion of the Nursing AdmissionScreening/History when a resident is admitted or readmitted. This training willalso include the directive to contact the physician if there is any abnormalityfound as a result of that assessment, and to document that physiannotification in the resident's clinical record.</p> <p>All licensednurses will be educated by the Director of Nursing and/or the Nurse Consultanton obtaining, transcribing, and following physician orders for all residents.This will include the process of identifying the orders that are received atthe time of admission or readmission; notifying the physician of the ordersthat have been received and verifying the orders that the physician wants inplace for the resident; making sure that any orders that the physician does notwant to continue are written as "discontinue" orders; inputting all the ordersverified with the physician into the clinical record promptly; notifying thepharmacy of all medication orders that are to be filled; and documenting</p>	

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	<p>P.M., the Nurse Practitioner indicated she was called during the night shift on 3/4/16, or possibly earlier AM on the 5th. She indicated she held the IV fluid and Magace order because she wanted to clarify what the physician wanted to do with the PICC line, as the resident was eating and drinking well. She indicated she thought the facility was doing accuchecks as the resident had episodes of very high and very low blood sugars. She indicated she had ordered blood sugars AC (before meals) and HS (bed time) with an insulin sliding scale. (Order was received on 3/9/16). When asked about her note dated 3/8/16, she indicated she was told by staff he was refusing blood sugars and she documented such in her note. The Nurse Practitioner indicated after 3 days the facility should have re-contacted her to clarify the hold orders, as standard practice.</p> <p>On 3/10/16 at 4:00 P.M., the Nurse Consultant provided a current policy titled "Central Venous Caterer Procedures," undated. The policy indicated "...Flush at least every 8 hrs [hours] when just using saline, every 12 hrs [hours] if using heparin."</p> <p>The Immediate Jeopardy that began on 02/26/16 was removed on 03/15/16, with an effective date of 03/15/16, when</p>		<p>the physician contact, receipt of orders, and other related activities in the resident's clinical record. All licensed nurses will be educated by the Director of Nursing and/or the Nurse Consultant regarding diabetic monitoring for diabetic residents, including the need for current orders for blood glucose testing and parameters for sliding scale coverage and/or physician notification.</p> <p>This training of licensed nurses will begin on March 9, 2016 and will continue for each shift until all nurses have received this education. Any licensed nurses that are off duty and not scheduled to work during this time period, will not be allowed to work until they have received the necessary training. All staff will sign an in-service document, as proof of their attendance.</p> <p>The Director of Nursing will schedule the charts of residents who are new admissions and readmissions to be reviewed as part of the next scheduled morning clinical management meeting which meets at least 5 days a week with the Administrator and IDT, to make sure that admission/readmission nursing assessments are completed, orders are transcribed appropriately and that diabetic residents have orders for monitoring their blood glucose. The IDT will offer recommendations for improvement or correction which will be followed up by the Director of Nursing as</p>				

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	<p>through observation, record review and interview, staff completed education related to glucose monitoring and demonstrated timely glucose monitoring. Staff also completed education related to accurate and timely completion of Nursing Admission Assessments and obtaining, transcribing and following physician orders. Even though the facility's corrective action removed the Immediate Jeopardy the facility remained out of compliance at a reduced scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not an Immediate Jeopardy because of on-going monitoring to ensure the staff were knowledgeable and the resident's glucose monitoring and physician orders were completed correctly.</p> <p>B.1. On 03/08/2016 at 12:06 P.M., Resident "B" was observed to have a purple oval area on his left upper forearm/elbow area.</p> <p>On 3/10/16 at 2:47 P.M., a review of the clinical record for Resident "B" was conducted. The record indicated the resident was admitted on 3/5/1998. The resident's diagnoses included but was not limited to; mental retardation, hypothyroidism, cerebral palsy, abnormal</p>		<p>indicated in question #2.</p> <p>B. If open areas, bruises, or other skin issues are identified, the nurse will assess each one with documentation of the area, including size and full description of each area. The physician is to be notified of any unusual skin issue and any orders that are received will be transcribed by the nurse receiving the orders, including documentation on the TAR for administration of treatments. An emphasis will be placed on making sure that physician orders are put into the electronic medical records system and they each is followed through by all nurses to make sure that the residents are receiving what the physician has ordered.</p> <p>If the DON or other IDT member finds that an assessment has not been completed or followed up by staff as necessary, they will notify the DON (if she is not already aware) who will make sure that the assessment is done as quickly as possible, with the results followed through as needed and reflected on the resident's care plan.</p> <p><u>1. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>In addition to the reviews done 5 times a week at the morning clinical management meeting, the Director of Nursing will bring</p>				

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	<p>posture, constipation and dysphagia.</p> <p>A care plan, dated 7/26/12, indicated the resident was at risk for bruising due to leaning in his wheelchair (w/c). The interventions included, but were not limited to: weekly skin assessments, notify MD (Medical Doctor) as needed, ensure harness in w/c fits properly with application, and side rails padded for seizure activity. Another care plan indicated the resident leans to the right while in his w/c and it was the resident's preference to lean in the w/c so he could propel himself.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 1/12/16, indicated the resident's Brief Interview Mental Status (BIMS) score was 10, moderate dementia. The MDS assessment further indicated the resident was totally dependent on staff for bed mobility, transfers, dressing, toileting and with personal hygiene.</p> <p>A Nurses Weekly Summary, dated 3/5/16, indicated the resident had no new changes to skin integrity. Another Nurses Weekly Summary, dated 3/13/16, indicated the resident had no new changes to his skin integrity.</p> <p>On 3/14/16 at 2:00 P.M., the resident was</p>				<p>the results of the chart monitoring reviews and audits related to the issues indicated in question #1, #2, and #3 to the weekly Standards of Care meeting, and then monthly with the QA Committee meeting. The QA Committee will review this information and will offer recommendations for further process improvement. These reviews and reporting will continue on an ongoing basis.</p> <p>Date of Compliance: 4/15/16 -</p>		

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	<p>observed to have a oval light purple-yellow area on his upper left forearm/elbow and measured approximately 5 centimeters.</p> <p>During an interview, on 3/14/16 at 8:50 A.M., the Director of Nursing (DON) indicated she was aware of Resident #1's bruise last week and had contacted his Level 2 specialized work representative to inquired about the bruise. The DON indicated the representative wasn't aware of the resident's bruise. The DON indicated she wanted to know if his work area might be the cause of the bruise. The DON further indicated she was unable to identify the cause of the bruise. The DON also indicated the bruise had not been assessed, measured or documented on in the resident's chart and conversation with the representative from Resident's specialized service program was not documented.</p> <p>During an interview on 3/14/16 at 11:50 A.M., the DON indicated her expectation would be the nurse who did the assessment (weekly summary) on 3/13/16 would of documented the bruise on the Resident's left upper forearm/elbow area. She didn't believe the bruise was there on the 3/5/16 weekly assessment as she first observed the bruise on Wednesday the 9th of March. She further indicated she</p>			

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	<p>thinks the process of assessments was dropped when the facility changed from paper charting to electronic charting.</p> <p>On 3/14/16 at 11:55 A.M., a policy was provided by the Nurse Consultant titled "Non-Pressure Skin Conditions," dated January 2005 and revised on October 2011 and indicated the policy was current. The policy indicated a licensed nurse will assess and document all non pressure skin conditions. Definition: "... A non-pressure skin condition is one that does not meet the criteria of pressure ulcers or venous, arterial or diabetic ulcers Stage 1 -IV. Examples of non-pressure conditions include, but are not limited to: rashes, excoriation, bruises, skin tears, open lesion, abrasions, laceration, and surgical wounds..."</p> <p>B.2. On 3/9/16 at 7:56 A.M., Resident #6 was observed being administered 5 units of Humalog (fast acting insulin) by subcutaneous injection by LPN (Licensed Practical Nurse) #3. After the injection the resident was observed propelling himself toward the dining room. He positioned himself at 8:08 A.M. in front of a table at the place he would usually sit. The resident's table had a plastic cup with juice in it, however the lid had a small opening for a straw and there was no straw placed in the cup for the</p>			

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	<p>resident.</p> <p>During an interview, on 3/9/16 at 8:21, LPN #3 indicated the resident needed a straw to drink his juice as resident was a choking risk.</p> <p>On 3/9/16 at 8:34 A.M., Resident #6 took his first bite of food, and straws were placed in his juice at 8:37 A.M.</p> <p>B.3. On 3/10/16 at 11:55 A.M., Resident #27 received Novolog (fast acting insulin) 15 units by subcutaneous injection. At 12:06 P.M., the resident was propelled to the dining room by a CNA (Certified Nursing Assistant) in his wheelchair and placed in front of a table. The resident's eyes were closed. The Social Service Director was observed placing the resident's lunch in front of him soon after he arrived at the table. The Social Service Director was observed walking away from the resident as soon as she placed the meal tray in front of him. The Social Service Director did not attempt to awaken the resident or ask him what he wanted to drink. At 12:19 P.M., LPN #3 was observed trying to awaken the resident, she asked for grape juice to be brought to the resident. LPN #3 attempted to have the Resident drink some juice. LPN#3 asked the resident to open his eyes and take a drink, and the</p>			

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	<p>resident responded and took several sips of the juice. LPN #3 then fed the resident a few bits of potatoes and the resident opened his eyes and completed his meal.</p> <p>During an interview, on 3/10/16 at 12:22 P.M., the Social Service Director indicated she was unaware of which residents in the dining area were obtaining insulin injections prior to their meal. She further indicated she had started at the facility 2 weeks ago.</p> <p>During an interview, on 3/10/16 at 12:30 P.M., LPN #3 indicated a resident who received fast acting insulin should eat or drink within 15 minutes.</p> <p>On 3/10/16 at 2:25 P.M., the Director of Nursing provided a policy titled, "Medications-General Policies," revised on 5/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...Fast acting insulin, such as Novolog or Humalog, will be administered within 15 of the scheduled meal time...."</p> <p>B.4. The clinical record for Resident #45 was reviewed on 03/08/16 at 2:45 P.M. Resident #45 was admited to the facility on 02/28/16 with diagnoses, including but no limited to: cerebral vascular accident, transient ischemic attack,</p>			

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	<p>paralysis of dominant side, hypertension and diabetes.</p> <p>The discharge orders for Resident #45 included the following instructions: "...4. Take medications for your diabetes as ordered and check sugars before each meal and at bedtime...."</p> <p>The February and March Medication Administration Record indicated there was no documentation of any blood sugar assessments for Resident #45.</p> <p>During an interview, on 03/09/16 at 9:00 A.M. she confirmed the facility had not been completing blood glucose assessments for Resident #45 because he was not insulin dependent.</p> <p>B.5. The clinical record for Resident #46 was reviewed on 03/08/16 at 3:00 P.M. and indicated he had been admitted to the facility on 03/02/16, with diagnoses, including but not limited to: massive pulmonary embolus and atrial flutter.</p> <p>The discharge orders from the acute care facility, dated 03/02/16, included an order for the blood pressure medication, Atenolol 25 mg (milligrams) orally daily. The Medication Administration Record for March 2016 from March 2 through March 9, 2016 indicated he had not been</p>			

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	<p>receiving his Atenolol medication.</p> <p>During an interview with the Director of Nursing, on 03/15/16 at 3:00 P.M., she indicated she had just missed the order when she was admitting the resident to the facility. She indicated since the resident had already discharge from the facility to his home, she had called to inform him of the error so he could start taking the medication.</p> <p>B.6. The clinical record for Resident #49 was reviewed on 03/15/2016 at 2:58 P.M. Resident #49 was admitted to the facility on 03/09/16, with diagnoses, including but not limited to: Alzheimer's disease, atherosclerotic heart disease, diabetes mellitus, hypothyroidism, gastro-esophageal reflux disease, hyperlipidemia, vascular dementia with behavioral disturbance, syncope and collapse, and hypertension.</p> <p>The initial nursing assessment, completed on 03/09/16 at 23:09 (11:09 P.M.) indicated there were no skin issues noted on the assessment.</p> <p>A Weekly skin assessment, completed on 03/10/16, indicated the resident's lower legs bilaterally present with "thick scaly skin." The resident stated she was being treated for them at the hospital with daily</p>			

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	<p>cleaning with a wound wash only, no water then a moisture cream and protective leggings. The note indicated there was no edema and no wounds present.</p> <p>The discharge orders from the hospital for Resident #49, dated 03/09/16, indicated the following:</p> <p>*"skin integrity. BLE [bilateral lower extremities] with hyperkeratosis, moisture breakdown in pannus fold and under breast."</p> <p>*Additional skin care/wound treatments BLE BID (twice a day)</p> <p>*Skin Care Supplies Sent with Patient BAZA (Antifungal) Cleanse and Protect Lotion Cleanser, Baza Clear Barrier Ointment, cotton stockinet</p> <p>*Additional Information Wound care included: BLE: Cleanse skin thoroughly with Baza cleanse and protect and washcloth. Apply Basza Clear ointment liberally to legs and feet. Place cotton stockinet sock to knees to keep ointment from being rubbed off. Perform care BID.</p> <p>*Pannus/Breast fold: Cleanse under pt (patient) pannu and breasts with Baza</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
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	<p>cleanse and protect and pat dry. Place Interdry AG (Absorbant fabric with antimicrobial Silver Complex) in pannus fold, place to fold line and lay in single layer. Allow 1-2 inches of fabric to remain exposed from under skin to wick moisture out of area. Do not use any other powders or creams with Interdry as it can clog the "pores" of the fabric and decrease effectiveness. May change out PRN (as needed) and rinse fabric with plain tap water and allow to air dry for reuse. Perform Care BID.</p> <p>The Medication and Treatment Administrator Record for Resident #49 for March 2016, reviewed on 03/12/16 at 5:00 P.M., indicated there was no documentation of the skin treatments on the forms.</p> <p>During an interview on 03/12/16 at 5:50 P.M., the Director of Nursing indicated the wound care had not been done. She indicated the resident had "dry skin" but no other skin issues on her pannus fold or legs. The Director of Nursing indicated she had given the resident some Lavender scented lotion to use on her dry skin.</p> <p>On 03/14/2016 at 930 A.M., Resident #49's feet and legs were observed in her room with the Director of Nursing. Resident #49 was noted to have long</p>			

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	<p>yellow thick gripper type socks and a very soiled stockinet underneath the socks on both legs.. As the resident attempted to pull the socks and stockinet down, large chunks of thick, brown colored dried skin fell onto the floor. The stockinet had a slightly yellowed tinge and multiple black colored chunks and crumbs of dried skin stuck to them. The resident's left and right leg from the knee clear through her feet were covered with a thick dried alligator looking cracked dried skin. The resident indicated she had came from the hospital with supplies and was using it herself. She indicated no one had treated her legs since she had been at the facility. During the observation, the DON attempted to tell the resident the facility needed to treat her skin, however the Resident argued with the DON about the issue. The resident was shown the physician's orders regarding her skin and a discussion indicated the resident would allow the treatment only twice a week but she felt like no one in the facility was "qualified." She indicated someone had helped her get her socks on yesterday. The resident at times would agree to have staff assist her but she reiterated no one had been helping her since she had been at the facility. The resident was also noted to have very long, dark colored toenails all all of her toes on both feet.</p>			

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	<p>The resident indicated there was no podiatrist available at the hospital. The resident indicated she would like to see a podiatrist while here. The DON indicated the resident had not allowed her to see her legs prior to the observation.</p> <p>B.7. The clinical record for Resident "D" was reviewed on 03/10/2016 at 10:54 A.M. Resident "D" was admitted to the facility on 11/06/15, and readmitted on 01/26/16 and discharged on 02/14/16. The resident's diagnoses on his 11/06/15 admission, included but were not limited to: Enterocolitis due to clostridium difficle, cerebral infarction, dementia without behavioral disturbance, muscle weakness, difficulty in walking, gastro-esophageal reflux, depressive disorder, anemia, dysphasia, diabetes mellitus, abnormal weight loss, macular degeneration, hypertension and hyperlipidemia.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 11/17/15, indicated the resident was moderately cognitively impaired, had no mood indicators, required extensive staff assistance of two staff for bed mobility, transfer needs, wheelchair locomotion, and toileting assistance and one person extensive assistance for dressing and personal hygiene. The resident only</p>				

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	<p>required supervision and set up help for eating needs. The resident was documented as having coughing and choking during swallowing medications and his weight was 141 pounds and had experienced significant weight loss and had one Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) pressure ulcer on admission.</p> <p>The acute care center discharge orders for Resident "D" included an order for the antifungal medication, Metronidazole (a medication to treat the resident's clostridium difficle infection) 250 mg (milligrams) tablets for 500 mg (2 tablets) by mouth every 8 hours. The Medication Administration Record for Resident "D" for November 2015 indicated he was only given Medronidazole 250 mg one tablet every 6 hours instead of the 500 mgs ordered.</p> <p>During an interview on 03/15/16 at 3:45 P.M., the Director of Nursing (DON) indicated a transcription error had been made for the Metrolmidazole dose. She indicated the discharge order from the acute care center indicated the resident was to receive Metrolmidazole 500 mg every 6 hours but instead the resident was</p>			

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	<p>given Metrolmidazole 250 mg every 6 hours. The DON indicated the facility policy and to have the next nurse working double check the orders transcribed for all new admissions. There was no documentation for this process so there was no way to tell if the orders had been double checked.</p> <p>Resident "D" had a gastrostomy tube placed to aid in his nutritional status on 12/31/15. On 01/12/16, Resident "D" was admitted to an acute care facility to treat and abdominal abscess and infection of the gastrostomy tube insertion site. He was readmitted to the facility on 01/26/16. The readmission orders included order for the resident to receive Zosyn 3.375 gm (grams)/50 ml (milliliters) per Intravenous line every 6 hours.</p> <p>The January 2016 Medication Administration Record for Resident "D" indicated he received the Zosyn antibiotic medication every 8 hours instead of every 6 hours, thus he missed one intended dose per 24 hours.</p> <p>During an interview, on 03/15/16 at 3:45 P.M., the Director of Nursing indicated there was a timing error for the Zosyn antibiotic which was ordered on the discharge orders from the acute care</p>			

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	<p>center on 01/26/16 and was to be given per intravenous route every 6 hours for 6 days but was only administered every 8 hours for 6 days.</p> <p>B.8. A clinical record review was completed, on 3/9/2016 at 12:25 P.M., for Resident #11. Resident #11 was admitted on 2/8/2016. The diagnoses included but were not limited to: kidney failure, aphasia, dysphasia, muscle weakness, difficulty in walking, arthropathy, constipation, arterosclerotic heart disease of native coronary artery without angina pectoris, gastritis without bleeding, secondary hypertension, and peripheral vascular disease.</p> <p>A care plan, dated 2/19/2016, indicated "...Ask the dialysis center to send documentation back to the facility, with me, of anything that they have done for me during my dialysis visit..." and "...Nursing to complete my post dialysis assessment after I return from dialysis...."</p> <p>During an interview on 3/9/2016 at 2:45 P.M., DON (Director of Nursing) indicated the facility does not have any documentation related to communication with the dialysis center and unable to locate any orders to monitor the residents dialysis access site.</p>			

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	<p>A physicians order indicated Resident #11 was to receive dialysis three times a week on Monday, Wednesday, and Friday.</p> <p>There was no diocumentation related to a dialysis assessment for Resident #11.</p> <p>During an interview on 3/10/2016 at 10:45 A.M., LPN (Licensed Practical Nurse) #3 indicated the facility did not have a form of communication related to dialysis services or assessments for Resident #11. She further indicated that there was no form of documentation she could access at the facility to inform her of the assessments performed at the dialysis center for Resident #11.</p> <p>On 3/7/2016 at 2:00 P.M., the DON provided a dialysis contract titled " SNF [Skilled Nursing Facility] OUTPATIENT DIALYSIS SERVICES AGREEMENT," dated July 1, 2013, and indicated this was the contract used for Resident #11. The contract indicated "...D. Mutual Obligations 1. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and ESRD [End Stage Renal Disease] Dialysis Unit. Documentation shall include, but not be limited to, participation in care</p>			

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	<p>conferences, continual quality improvements program, annual review of infection control of policies and procedures, and the signatures of team members from both parties on a Short Term Care Plan (STCP) and Long Term Care Plan (LTCP). Team members shall include the physician, nurse, social worker and dietitian from the ESRD Dialysis Unit and a representative from the Nursing Facility. The ESRD Dialysis Unit shall keep the original the STCP and LTCP in the medical record of the ESRD Resident and the Nursing Facility shall maintain a copy...."</p> <p>On 3/10/2016 at 11:15 A.M., the Corporate Nurse provided the policy titled "Hemodialysis," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated "...GUIDELINES: The Dialysis Unit should provide a written progress note of some type regarding the pertinent issues that were observed or occurred during the dialysis visit. It should also include the amount of fluids that the resident consumed during his/her visit...." and "...6. Assess resident upon return from dialysis and document findings on Post Dialysis Assessment form. If there are additional observations, the nurse will document them in the residents's chart...." and</p>			

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F 0312 SS=D Bldg. 00	<p>"...Document resident's status on the Post Dialysis Assessment form when returning from dialysis...."</p> <p>This Federal tag relates to Complaint IN00193960.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interviews, the facility failed to provide grooming, dressing and incontinence care for 2 of 3 residents reviewed for activities of daily living (ADL'S) who required staff assistance. (Resident #31 and "F")</p> <p>Findings include:</p> <p>1. The clinical record for Resident #31 was reviewed on 3/9/16 at 10:15 A.M. Resident #31 was admitted to the facility, on 2/6/12, with diagnoses, including but</p>	F 0312	<p>It is the policy of this facility to provide grooming, dressing and incontinence care for residents who require staff assistance.</p> <p>1. <u>What corrective action will be done by the facility?</u> Resident #31 will have a new bowel and bladder assessment done by 4/15/16. Resident I will have a bladder assessment redone by 4/15/16. Based on the results of that assessment, their care plans will be updated to accurately reflect the status of the bladder and/or bowel, including an individualized plan to check, toilet, and change the resident on a</p>	04/15/2016

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	<p>not limited to : Alzheimer's disease, adult failure to thrive, diabetes mellitus type II and osteoarthritis of the hip.</p> <p>A Braden Scale for predicting pressure sore risk, dated 1/4/16, indicated the resident was at high risk for developing pressure ulcers related to the degree to which skin is exposed to moisture: very moist: skin is often, but not always moist. The resident is bedfast and very limited related to mobility.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 1/5/16, indicated the resident was severely cognitively impaired, required total dependence two plus person assist with transfers and toilet use and extensive two person physical assist for bed mobility. The resident was documented as always incontinent of her bladder.</p> <p>A care plan, dated 1/7/16, indicated the resident was incontinent of both bowel and bladder due to Alzheimer's disease. The interventions included, but were not limited to: I am to be cleansed and dried after each incontinent episode. I require staff to check and change me every two hours and as needed. I want to wear a brief to maintain my dignity. I will have a bowel and bladder assessment completed upon admission/readmission, quarterly,</p>		<p>frequent basis in order to keep skin as clean and dry as possible. Nursing staff will be in-serviced by the DON and Nurse Consultant on completion and timeliness of bowel and bladder assessments, as well as inclusion of appropriate interventions on the residents' plans of care. For Resident F a new bladder assessment will be done by 4/15/16. At this time, he has demonstrated more consistent continence, and his care plan will be adjusted to the results of the bladder assessment to demonstrate his current status, including the restorative nursing program for toileting. That program will be listed on the CNA assignment for staff reference when toileting him. Resident F has received appropriate personal care since the survey. This resident has a tendency to move throughout the facility on his own when up, and staff will be in-serviced on the need to assist him and other residents who require help with personal care throughout the day on a routine basis. The Nurse Consultant will in-service the IDT members regarding the Guardian Angel Program and the observations that they should be making for the residents that are assigned to them, including the status of each one's personal care each time that they visit. 2. <u>How will the facility identify other residents having the potential to be affected</u></p>				

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	<p>annually, with significant changes and as needed.</p> <p>A care plan, dated 1/7/16, indicated the resident required staff assistance with completing daily care/activities related to impaired mobility and that the resident was dependent on staff for all of her ADL's and required a full hoyer for transfers with two assist. The interventions included, but were not limited to: I am to receive incontinence care with each episode. I need staff of two and hoyer with all transfers.</p> <p>A Certified Nursing Assistant (CNA) worksheet, undated, indicated Resident #31 required a 2 person hoyer (lift device) transfer, wears briefs due to bowel and bladder incontinence, was to be checked and changed, and was total assist with all activities of daily living (ADL).</p> <p>On 3/9/16 from 8:05 A.M. to 9:03 A.M., Resident #31 was observed seated in her Broda (reclining wheelchair) chair in the assisted dining room, the staff was feeding the resident her breakfast. At 9:04 A.M., the resident was taken by staff from the assisted dining room and placed in the hallway outside of her room. At 9:10 A.M., the resident was taken in her Broda chair by the Activity Director for a</p>		<p><u>by the same practice and what corrective action will be taken?</u> All residents who are incontinent or require assistance with toileting and personal care have the potential to be affected. Care plans and CNA assignment sheets will be updated to reflect any changes in interventions that occur as a result of the assessments. If any member of the IDT becomes aware of or observes residents who are not being toileted or changed as per the residents' needs, who are not being repositioned and checked at least every 2 hours, or who are not receiving assistance with personal care, he/she will report the issue directly to the Administrator and DON, who will begin an investigation immediately to resolve the issue as quickly as possible. Once the resident situation is taken care of, the DON will re-train the staff involved and will render progressive disciplinary action as indicated by the situation for continued noncompliance.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u> The DON/designee will perform an ADL audit 5 times a week for 30 days and then twice a week for 30 days and then weekly ongoing. Any concerns noted during the audit will be addressed immediately. She will complete the ADL auditing tool and bring her findings to the QA meeting monthly. 4. How will</p>		

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	walk in the hallway. At 9:15 A.M., the Activity Director brought the resident back to her room and placed the resident in the hallway outside of her room where she remained until 10:22 A.M. when the Activity Director assisted the resident in her Broda chair to the dining room for an activity. At 11:09 A.M., the resident was assisted by the Activity Director from the main dining room into the assisted dining room. The resident remained in the assisted dining room until 1:15 P.M. At 1:15 P.M., the resident was propelled in her Broda chair by a CNA and placed in the hallway outside of her room. From 1:15 P.M. to 3:15 P.M., the resident remained outside of her room in the hallway seated in her Broda chair. At no time was the resident observed to be checked or changed. At 3:20 P.M., CNA #25 was questioned if the resident ever lays down in the afternoon the CNA indicated "sometimes." At 3:25 P.M., CNA#25 and CNA#26 assisted Resident #31 into bed with the use of the hooyer lift. As the resident was lifted from her Broda chair there was a strong foul smelling urine odor, the pressure relieving cushion in the Broda chair was wet, the resident's light tan slacks had a large wet stain on the back of them. The brief was saturated with a strong foul smelling urine odor, the resident had a moderate amount of soft brown bowel		<u>corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or other designated members of the IDT will bring the result of their audits to the weekly Standards of Care meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the assigned member of the IDT and the results of those recommendations will be brought back to the next scheduled QA Committee meeting for review. When the written audits have shown 100% compliance, the QA Committee may decide to stop them; however, the monitoring by the IDT members will continue as indicated on an ongoing basis. Date of Compliance: 4/15/16	

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	<p>movement in the brief. A Mepilex dressing to the coccyx area was wet with urine and the dressing was coming off of the coccyx area. LPN (Licensed Practical Nurse) #27 came into the room to remove the soiled dressing to the coccyx and apply a new dressing. LPN #27 indicated the resident had an open area on her coccyx, she further indicated the area is healed now but the dressing continues to the area for protection. The skin to the coccyx was observed no open areas were observed.</p> <p>During an interview, on 3/9/16 at 3:30 P.M., CNA #26 indicated she works the evening shift and receives report from the day shift before they leave for the day. She indicated the resident should have been changed by the day shift after lunch because she is a check and change every 2 hours and as needed.</p> <p>During an interview, on 3/14/16 at 10:44 A.M., the Director of Nursing indicated the resident should be checked and changed after each meal, at HS (bed time) and as needed.</p> <p>2. Resident "F's" record was reviewed on 3/9/16 at 10:42 A.M., and indicated the resident was admitted to the facility on 2/13/14, with diagnoses, including but not limited to, dementia without</p>			

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	<p>behavioral disturbance, enlarged prostate, syncope, convulsions, muscle weakness and psychotic disorder with hallucinations.</p> <p>The annual MDS(Minimum Data Set) assessment, completed on 12/8/15, indicated the resident is frequently incontinent, is on a urinary toileting program, requires extensive 1 person assist for dressing and personal hygiene, limited 1 person assist for transfers and toileting and total dependence for bathing. The BIMS (Brief Interview for Mental Status) score was 4 indicating the resident has severe dementia.</p> <p>A Bladder Assessment Form, dated 12/8/15, indicated the resident is currently incontinent of bladder and a 5 day voiding pattern would start on 12/12/15 at 6:00 A.M. The Director of Nursing (DON) was unable to locate the 5 day voiding pattern form. The DON indicated the form should be on the paper chart.</p> <p>A care plan, dated 12/11/15, indicated the resident was frequently incontinent of his bladder and required a restorative toileting program to decrease his incontinent episodes. The interventions included, but were not limited to: staff prompting him to void and assist him to</p>			

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	<p>the bathroom every 2 hours.</p> <p>A care plan, dated 12/16/15, indicated the resident required staff assistance with completing his daily care/activities related to his impaired mobility and that he required assistance with transfers, bed mobility, toileting, dressing, personal hygiene and bathing due to his diagnosis of dementia, lack of coordination and muscle weakness. The interventions included, but were not limited to: he was to receive assistance with showers, toilet use, transfers and incontinence care with each episode. The resident was to receive assistance with oral care twice daily, assistance with picking out his clothes daily and set up of his personal hygiene items.</p> <p>A Certified Nursing Assistant (CNA) assignment sheet, undated, indicated Resident "F" required 1 assist for all ADL's, dressing and grooming and to assist with toileting. There was no information on the CNA assignment sheet indicating the resident was on a restorative toileting plan.</p> <p>On 3/9/16 at 9:01 A.M. Resident "F" was observed in the assisted dining room, he was wearing a gray hooded sweatshirt and a blue pair of sweat pants. His eyes were matted, his face was unshaven and</p>			

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	<p>his fingernails were long and a dried brown substance was observed under the nails. At 9:10 A.M., the resident propelled himself in his wheelchair to the hallway outside of his room, he had a full bottle of orange soda in his hands. While sitting in his wheelchair he fell asleep the soda fell out of his hands spilling a small amount of soda onto his sweatpants and onto the carpeted floor in the hallway. At 9:42 A.M., the resident propelled his wheelchair into his room where he was observed to transfer himself to his bed. From 10:30 A.M. to 12:00 P.M., the resident rested in his bed, he was not observed during this time to take himself to the bathroom nor was staff observed to enter his room and offer to take him to the restroom. At 12:05 P.M., CNA #22 entered the residents room and indicated to the resident it was time for lunch. CNA #22 was observed to transfer the resident from his bed to his wheelchair and then propel him to the dining room. CNA #22 was not observed to assist the resident to the restroom.</p> <p>An ADL form, dated March 2016, indicated Restorative Toileting: Assist me to the bathroom between 8-8:30 A.M., 9:30-10 A.M., 1-1:30 P.M., 3:30-4 P.M., 6-6:30 P.M. and just before I go to bed with one staff assist. On 3/9/16 during the day shift there was only one</p>			

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	<p>time documented that the resident was assisted to the bathroom at 1:59 P.M.</p> <p>On 3/10/16 at 8:45 A.M., Resident "F" was observed in his wheelchair in the assisted dining room, he was wearing the same gray hooded sweatshirt and a blue pair of sweatpants. His eyes were matted, his face unshaved and his fingernails were long with a brown substance observed under the nails. At 9:00 A.M., the resident propelled his wheelchair from the dining room to his room and transfers himself back to bed. From 10:00 A.M. to 12:00 P.M., the resident was observed resting in his bed. The resident was not observed during this time to take himself to the bathroom, nor was staff observed to enter his room and assist him to the bathroom. At 12:05 P.M., CNA # 22 transferred the resident from his bed to his wheelchair and then propelled him to the dining room she did not assist him to the restroom prior to the meal.</p> <p>During an interview, on 3/10/16 at 12:07 P.M., CNA #22 indicated the resident requires a 1 person assist for transfers. She further indicated the resident receives showers on the evening shift at least 3 times per week which would include shaving him and performing nail care at that time. She indicated the</p>			

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	<p>resident is incontinent and wears a brief, she was not aware the resident was on any kind of toileting program.</p> <p>On 3/10/16 at 4:00 P.M., RN (Registered Nurse) #20 provided a policy titled "Bath-Bed, Partial, Shower, Tub", dated June 2004, and indicated the policy was the one currently used by the facility. The policy indicated "...Bed Bath Procedure:...16. Care of fingernails and toenails is part of the bath. Be certain nails are clean. If toenails would be difficult to care for, inform the nurse that the resident needs to see the podiatrist...."</p> <p>During an interview, on 3/15/16 at 3:17 P.M., the Administrator indicated the facility has a guardian angel program in place and that all of the residents have a guardian angel. If the residents guardian angel observes a concern with personal hygiene including nail care they would let the nursing staff know the residents nails needed to be trimmed ad cleaned.</p> <p>This Federal tag relates to Complaint IN00193960.</p> <p>3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(4) 3.1-38(b)(6)</p>			

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F 0314 SS=G Bldg. 00	<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, record review and interviews, the facility failed to ensure a resident admitted without a pressure ulcer received appropriate assessments and interventions to prevent the development of a pressure ulcer for 1 of 4 residents reviewed for skin issues. (Resident #11) In addition, the facility failed to ensure a thorough assessment and appropriate treatment orders were obtained for a resident admitted with a pressure ulcer in a sample of 1 of 4 residents reviewed for pressure ulcers. (Resident #47) Lastly, the facility failed to ensure a resident was a chronic pressure ulcer had accurate assessments and interventions provided as planned to promote healing for 1 of 4 residents reviewed for pressure ulcers.</p>	F 0314	<p>It is the policy of this facility to ensure that a resident admitted without a pressure area receives appropriate assessments and interventions to prevent the development of a pressure ulcer; to ensure a thorough assessment and appropriate treatment orders upon admission for a resident with a pressure ulcer; and to ensure that residents with chronic pressure ulcers have accurate interventions and assessments to promote healing. 1. <u>What corrective action will be done by the facility?</u> Resident #6 has a referral to therapy for assessment of his wheelchair seating to make sure that it is appropriate to his needs. The nursing staff will be reminded that even though Resident #6 often refuses to</p>	04/15/2016

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	<p>(Resident #6)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #6 was reviewed on 03/11/2016 9:30:16 AM . Resident #6 was admitted to the facility on 05/16/03 with diagnosis, including but not limited to: diabetes, cerebrovascular disease, hemiplegia, dysphagia, hypertension, atrial fibrillation, major depressive disorder single episode, enlarged prostate, hyperlipidemia and hypothyroidism. A diagnosis of pressure ulcer was added on 07/05/11.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 01/15/16 indicated the resident had a stage 2 pressure area with granulation which had been present since 02/11/15. The resident also required extensive staff assistance for transfers, toileting, and was occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>The care plans, current through 04/15/16, included the following interventions related to bowel incontinence to check the resident every two hours and assist with toileting as needed. A care plan related to the resident's risk for skin</p>		<p>move from the wheelchair for any reason, including toileting, they are to always check him for changing and/or ask him if he would like to go to the bathroom. His care plan has been updated to reflect this approach, as well as his frequent refusal to move from the hallway to receive blood glucose checks or administration of insulin. Resident #47 is no longer at the facility. Resident #11's open area to his left arm was healed – he is no longer at the facility. Nursing staff will be in-serviced on the facility policy for documentation of skin assessments upon admission and then weekly for all residents; notifying the physician and obtaining orders for treatment of the identified areas; and documentation of administration of treatment orders on the treatment administration record (TAR), and documentation of showers or bathing for every resident as per their preferences.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents with pressure areas or other wounds have the potential to be affected by this practice. The DON and Nurse Consultant will review each resident with a wound to make sure that wound assessments, treatment orders, documentation of the treatment administration, and</p>		

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	<p>breakdown included interventions to provide incontinent care with each episode, pressure relieving cushion to my wheelchair, pressure relieving mattress on my bed, turn and reposition every 2 hours while in bed and as needed, and weekly skin assessment by charge nurse. A plan to address the resident's refusal of care included a goal for the resident to agree to lay down after at least one meal daily to promote increased healing of the wound on his buttocks. The interventions included, but were not limited to: allow me to make decisions about my treatment regimen, educate me of possible outcomes of not complying with treatment of care, give clear explanations of all care activities, provide me with opportunities for choice during care provision and remind me of benefits/consequences of my decisions.</p> <p>Resident #6 was observed, on 03/11/16 at 8:37 A.M., seated in his wheelchair in the assisted dining room. He was propelled in his wheelchair by staff back to the hallway just outside his room at 9:07 AM. He was then observed at 9:15 AM seated in the back hallway by his room door in his wheelchair. He indicated his wheelchair was newer but was not comfortable as the seat was too short. The resident's stomach protruded in his front and it was hard to determine if the</p>		<p>shower/bathing documentation is in place. The care plans for those residents have been reviewed to make sure that the interventions are current with the residents' condition. If the DON identifies any residents with wounds who have not been addressed as per policy, she will intervene at that time and make sure that the needed documentation or services are completed satisfactorily. When that is done, she will re-train the staff involved, rendering progressive discipline for continued noncompliance at that time.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> The DON has done 100% audit of residents' skin and documented her assessment of any issues that were found including notification of family and physician. The DON/designee will measure and document on all skin concerns weekly until healed. The DON will audit the assessments 5 times a week for 30 days and bring her findings to the morning management meeting and complete auditing tool F272/314 with her findings. During resident's care plans the IDT will review the resident's current preference for her/his shower days/times and make any changes that the resident requests. The resident's preferences will be put on the Shower list and CNA assignment sheet. The DON will audit the</p>	

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	<p>wheelchair fit him properly. The resident's body obscured visualization of any wheelchair pad but he indicated he had all kinds of pads in the wheelchair seat.</p> <p>Resident #6 remained in his wheelchair sleeping, at times snoring from 9:14 A.M. to 11:53 A.M. when LPN (Licensed Practical Nurse) #50 took his blood sugar in the hallway. LPN #50 informed the resident he needed some insulin and she administered the insulin to the resident in the hallway because the resident did not want to go into his room. The resident remained in his wheelchair beside his room door until 12:08 P.M., when a Certified Nursing Assistant (CNA) took him down the hallway towards the dining room. She did not offer to toilet the resident or assist him to move in his wheelchair. The staff member pushed his approximately 1/2 way down the hallway and the resident was then observed to slowly propel himself in his wheelchair directly into the assisted dining room.</p> <p>The resident remained in his wheelchair at the table eating his meal and was still in the dining room at 1:15 P.M.</p> <p>At 1:26 P.M., CNA #56 pushed Resident #6 from the dining room straight to the back hallway just outside his room door</p>		<p>showers given 5 times a week for 30 days, then 2 times a week for 30 days and then weekly ongoing and document her findings on the F312/314 ADL Audit tool. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the result of her audits and observations to the weekly Standards of Care meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the DON and the results of those recommendations will be brought back to the next scheduled QA Committee meeting for review. This will continue on an ongoing basis. Date of Compliance: 4/15/16</p>	

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	<p>and turned the resident's wheelchair so he faced the hallway. She did not ask him to move or offer to toilet the resident but she did give the resident a hug when he requested a hug. The resident remained in his wheelchair with no position change or any care offering by staff until 2:05 P.M. when he rang a bell and informed CNA #52 he needed to go to the bathroom. She informed him she needed to go get some help and she would be back to assist him.</p> <p>On 03/11/16 at 2:27 P.M. Resident #6 was assisted with two nursing assistants to stand, pivot and sit on the toilet. After the resident used the bathroom, the resident's open area was observed with LPN #57. The resident's buttocks and scrotum were very discolored and pendulous. There was a covered, silver dollar sized open area with frank blood dripping from the wound noted on what appeared to be below the resident's buttocks area. LPN #57 indicated the dressing was usually changed by night shift so she was not aware of the status of the wound. There was a moderate to large amount of sanguineous drainage noted on the removed dressing. The edges of the wound, approximately soft ball sized was dark purple in color. The nurse then cut a silver dollar sized piece of the ordered alginate dressing and</p>			

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	<p>placed an absorbent dressing over the whole wound. The absorbent dressing was very large and did not adhere to the resident's skin. The nurse indicated she thought the open wound was on the resident's scrotum. There were several bloody thin elongated areas approximately 1/4 inch by 2 inches long on the other side of the resident's scrotum.</p> <p>The wound assessment information, completed on 03/09/16, by the Director of Nursing indicated the resident had a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) pressure area on his right buttocks. The body diagram denoted a black circle in the middle of the resident's right buttocks as the location of the pressure area. The area was documented as measuring 6 centimeters long by 4 centimeters wide by .1 centimeters depth with 100 percent red granulation in the wound bed, no slough, and regular edges. The note indicated the resident's wound was healing.</p> <p>During an observation of Resident's pressure ulcer observation, with the Director of Nursing (DON), on</p>			

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	<p>03/14/2016 at 3:18 P.M., the following was observed: There was a tennis ball sized red area on the residents right ischium, below the resident's buttocks. The center of the wound was opened, slightly smaller than a baseball size and had some slough, gray in color, y-shaped in the center and deepest point of the wound. There was also an odor noted. There was also some frank blood in the wound and in open wounds on the resident's scrotum. The DON indicated he was on Coumadin and his wound bled. The resident's right ishium as well as his scrotal area was discolored a dark purple.</p> <p>A wound assessment, documented by the Director of Nursing, on 03/14/16 at 2:56 P.M., (not actual time of observation and treatment), indicated the resident had a Stage II pressure area located on his right buttocks. A black circle on the body diagram still indicated the wound was in the center of his right buttocks. The assessment indicated the wound was 7.0 by 6.5 centimeters by .1 centimeters in depth, had no slough, was 100 percent granulated, and had irregular edges and the periwound was macerated, purple, dark, and scaly. There was a note that indicated the area was larger, the skin as peeling back in the upper portion of the right buttocks, and there was a moderate amount of bleeding noted The note</p>			

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	<p>indicated the resident had been refusing the treatment twice a day frequently and would not lay down for the nurse to do the treatment during the day. There were also several small sores on his scrotum with dry scaly skin noted. The note indicated the area was cleansed and barrier ointment applied. The open area had calcium alginate applied to the wound bed and mepilex dressing over it.</p> <p>The documentation of twice a day dressing changes indicated the resident was receiving the dressing changes twice a day, even though the Director of Nursing indicated the resident refused to allow the day shift to change his dressing.</p> <p>Although there was a care plan to reflect the resident's refusal of care, including laying down after meals, there was no documentation the care was attempted and the resident refused.</p> <p>In addition, the resident was observed continually between breakfast and lunch and no staff attempted to offer the resident the planned interventions to promote pressure ulcer healing.</p> <p>2. On 3/9/16 a 9:22 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was admitted on 2/26/16 and</p>			

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	<p>re-admission on 3/4/16. The resident's diagnoses included, but were not limited to: adult failure to thrive, chronic obstructive pulmonary disease, insulin dependent diabetic-uncontrolled, chronic embolism/thrombosis of deep veins of lower extremity (bilateral), viral hepatitis and congestive heart failure.</p> <p>A hospital History & Physical, dated 2/26/16, indicated the resident had a decubitus ulcer on his buttock, multiple abrasion on lower extremities, some areas open/seeping others scabbed and multiple abrasions on forearms as well.</p> <p>A form titled "Licensed Nurse Weekly Skin Assessment," dated 2/26/16, indicated the resident was admitted with a pressure ulcer on his coccyx, a bruise on his left elbow and multiple scrapes on his lower extremities. There were no measurements or staging of the coccyx pressure ulcer or measurements of other skin abnormalities. The resident's Braden score was 16 which indicated the resident was at high risk for skin breakdown.</p> <p>A physician's order, dated 3/1/16, indicated to apply mepilex dressing (a wound dressing) on the resident's coccyx daily and as needed. There were no orders for the treatment of the Resident's Stage II coccyx pressure ulcer prior to</p>						

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	<p>3/1/16.</p> <p>The Treatment Administration Record (TAR) indicated the resident had not received wound care and/or dressing changes on 2/26, 2/27, 2/28 and 2/29/16. The Director of Nursing (DON) was unable to locate a treatment order and/or dressing changes for the Stage II coccyx pressure ulcer when the resident was admitted on for 2/26.</p> <p>A care plan, dated 3/9/16, indicated the resident was at risk for a pressure ulcer and currently had a stage II ulcer on his coccyx due to history of poor nutrition and failure to thrive.</p> <p>On 3/11/16 at 10:35 A.M., an observation of the Resident #47's coccyx wound ulcer was completed with the Director of Nursing (DON). The resident was observed to have a Stage II coccyx pressure ulcer which measured 1.0 x 0.7 x 0.1 centimeters.</p> <p>On 3/14/16 at 9:20 A.M., the Administrator provided a current policy titled, "Discovering/Reporting New Pressure Ulcers", dated January 2005 and revised on October 20011. The policy indicated "OBTAINING PHYSICIAN'S TREATMENT ORDERS: In order to heal pressure ulcers and other skin</p>			

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	<p>conditions, the nurse must get a treatment order from the physician...."</p> <p>3. A clinical record review was completed on 3/9/2016 at 12:25 P.M., for Resident #11. Resident #11 was admitted on 2/8/2016. The diagnoses included, but were not limited to: kidney failure, aphasia, dysphasia, muscle weakness, difficulty in walking, arthropathy, constipation, arteriosclerotic heart disease of native coronary artery without angina pectoris, gastritis without bleeding, secondary hypertension, and peripheral vascular disease.</p> <p>A care plan, dated 2/19/2016, indicated "...Observe my feet with baths and weekly skin assessments to ensure no other issues are occurring...." and Make my physician and family aware of any changes/worsening to my skin condition...."</p> <p>A care plan dated 2/25/2016 indicated "...My skin condition will be monitored at least twice a week by the CNA (certified nursing assistant) during my shower and weekly by the charge nurse...."</p> <p>A care plan, dated 3/14/2016, indicated "...Open skin area(s): stage 2 pressure area on left inner buttock...."</p>			

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	<p>A care plan, dated 2/25/2016, indicated "...My skin condition will be monitored at least twice a week by the CNA during my shower and weekly by the charge nurse...."</p> <p>An MDS (Minimum Data Set), dated 2/18/2016, indicated Resident #11 was at risk for a pressure ulcer.</p> <p>A shower schedule, dated 1/28/2016, indicated Resident #11 was to be assisted with a shower every Monday and Thursday.</p> <p>A CNA(certified nursing assistant) documentation report indicated Resident #11 had not received a shower from March 2 thru March 9.</p> <p>During an interview on 3/10/2016 at 9:44 A.M., the Corporate Nurse indicated there was no documentation for Resident #11 receiving showers at the facility. She further indicated that there was no documentation of a complete skin assessment completed on Resident #11.</p> <p>During an interview on 3/14/2016 at 11:31 A.M., the DON (Director of Nursing) indicated she was unaware Resident #11 had a pressure ulcer until this morning.</p>			

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F 0315 SS=D Bldg. 00	<p>During an observation on 3/14/2016 at 9:25 A.M., LPN #3 indicated Resident #11 had a new Stage II pressure ulcer. She further indicated the area had a 1.5 cm (centimeter) x 1 cm open area and a 7 cm x 5 cm area of red/purple area to left buttocks.</p> <p>On 3/14/2016 at 10:54 A.M., the Coporate Nurse provided the policy titled "Skin Assessments," dated June 2004, and indicated this was the policy currently used by the facility. The policy indicated "...1. Head to toe assessments will be done weekly, with special attention being addressed to areas more prone to skin breakdown, such as ears, shoulder blades, elbows, coccyx, buttocks, heels, outer aspect of feet, inner aspect of feet...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a</p>			

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	<p>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>A. Based on observation, interview and record review the facility failed to ensure the justification for the use of an indwelling Foley catheter for 1 of 2 residents with Foley catheters. (Resident #47)</p> <p>B. Based on observation, record review, and interviews, the facility failed to provide incontinence care to 2 of 2 resident's reviewed for incontinence care. (Resident #31 and "I")</p> <p>Findings include:</p> <p>A. During the initial tour, on 3/7/16 at 9:50 A.M., Resident #47's indwelling Foley catheter was observed from the hallway.</p> <p>During an interview, on 3/7/16 at 2:57 P.M., Agency Nurse #1 indicated Resident #47 did not have an indwelling Foley catheter. Agency Nurse #1 further indicated the resident had recently went to the hospital and she just wasn't sure if the Resident had returned to the facility</p>	F 0315	<p>It is the policy of this facility to ensure justification of the use of Foley catheters and to provide incontinence care when needed.</p> <p>1. <u>What corrective action will be done by the facility?</u> Resident #47 is no longer a resident of this facility. Nursing staff will be in-serviced by the DON and Nurse Consultant regarding the need for an order for the use of a Foley catheter, written assessment and justification for the use of a Foley catheter, and the proper care of a Foley catheter, including the need to keep the tubing from touching the floor. Resident #31 will have a new bowel and bladder assessment done by 4/15/16. Resident I will have a bladder assessment redone by 4/15/16. Based on the results of that assessment, their care plans will be updated to accurately reflect the status of the bladder and/or bowel, including an individualized plan to check, toilet, and change the resident on a frequent basis in order to keep skin as clean and dry as possible. Nursing staff will be in-serviced by the DON and Nurse Consultant on completion</p>	04/15/2016

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	<p>with a Foley catheter or not. She then indicated the justification for the use of the Foley catheter was incontinence.</p> <p>On 3/8/16 at 9:44 A.M., Resident #47's Foley catheter was observed on the floor and draining amber colored urine into the catheter bag.</p> <p>On 3/9/16 at 7:28 A.M., Resident's indwelling Foley catheter was observed hanging on the bed rail, draining amber yellow urine.</p> <p>On 3/9/16 a 9:22 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was admitted on 2/26/16, and readmitted on 3/4/16. The resident's diagnoses included but was not limited to: adult failure to thrive. chronic obstructive pulmonary disease, diabetes, chronic embolism/thrombosis of deep veins of lower extremity (bilateral) and congestive heart failure.</p> <p>The physician orders, dated 3/4/16, from the hospital did not contain an order for an indwelling Foley catheter.</p> <p>During an interview, on 3/9/16 at 11:10 A.M., the Director of Nursing (DON) indicated she did not have an order for the catheter, but had an order to</p>		<p>and timeliness of bowel and bladder assessments, as well as inclusion on the residents' plans of care with appropriate interventions. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents who are incontinent, require assistance with toileting, or have a Foley catheter have the potential to be affected by this practice. Care plans and CNA assignment sheets will be updated to reflect any changes in interventions that occur as a result of the assessments. If the DON finds that bowel and bladder assessments are not completed with a corresponding plan of care; if she finds that the staff are not following the plan of care for toileting or incontinence care; Foley catheters being used without appropriate justification or assessment, or Foley catheters which are not receiving appropriate services, she will intervene immediately to correct the situation. If any member of the IDT becomes aware of or observes residents who are not being toileted or changed as per the residents' needs, who are not being repositioned and checked at least every 2 hours, or who are not receiving assistance with personal care, he/she will report the issue directly to the Administrator and DON, who will begin an investigation</p>		

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	<p>discontinue the catheter.</p> <p>A Physician's order, dated 3/8/16, indicated to dc (discontinue) Foley due to no justification for use.</p> <p>A Progress Note, dated 3/9/16 at 17:25 P.M., indicated "...Foley Catheter removed without difficulty...."</p> <p>On 3/11/16 at 12:10 P.M., the DON provided a current policy titled "Catheter Care - General Information," dated June 2004. The policy indicated "5. Cleaning a. Inspect the area around the urethral orifice and catheter at least 1 time per shift for cleanliness and dryness...." The policy did not address the need to have a physician's order for an indwelling Foley catheter.</p> <p>B.1. The clinical record for Resident #31 was reviewed on 3/9/16 at 10:15 A.M. Resident #31 was admitted to the facility, on 2/6/12, with diagnoses, including but not limited to : Alzheimer's disease, adult failure to thrive, diabetes mellitus type II and osteoarthritis of the hip.</p> <p>A Braden Scale for predicting pressure sore risk, dated 1/4/16, indicated the resident was at high risk for developing pressure ulcers related to the degree to which skin is exposed to moisture: very</p>		<p>immediately to resolve the issue as quickly as possible. Once the resident is taken care of, she will re-train the staff involved with progressive disciplinary action for the noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u>1. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will audit 5 times weekly for 30 days, then twice weekly for 30 days then weekly ongoing and document her findings on the ADL Audit Tool F312/314/315. The DON will bring the results of her audits and observations to the weekly Standards of Care meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the assigned member of the IDT and the results of those recommendations will be brought back to the next scheduled QA Committee meeting for review. When the written audits and observations have shown 100% compliance, the QA Committee may decide to stop them; however, the monitoring by the IDT members will continue as indicated on an ongoing basis.</p>		

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	<p>moist skin is often, but not always moist. The resident is bedfast and very limited related to mobility.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 1/5/16, indicated the resident was severely cognitively impaired, required total dependence two plus person assist with transfers and toilet use and extensive two person physical assist for bed mobility. The resident was documented as always incontinent of her bladder. A bowel and bladder assessment could not be located on the paper or electronic charting for Resident #31.</p> <p>A care plan, dated 1/7/16, indicated the resident was incontinent of both bowel and bladder due to Alzheimer's disease. The interventions included, but were not limited to: I am to be cleansed and dried after each incontinent episode. I require staff to check and change me every two hours and as needed. I want to wear a brief to maintain my dignity. I will have a bowel and bladder assessment completed upon admission/readmission, quarterly, annually, with significant changes and as needed.</p> <p>A Certified Nursing Assistant (CNA) worksheet, undated, indicated Resident #31 required a 2 person hoyer (lift</p>						

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	<p>device) transfer, wears briefs due to bowel and bladder incontinence, was to be checked and changed, and was total assist with all activities of daily living (ADL).</p> <p>On 3/9/16 from 8:05 A.M.to 9:03 A.M., Resident #31 was observed seated in her Broda (reclining wheelchair) chair in the assisted dining room, the staff was feeding the resident her breakfast. At 9:04 A.M., the resident was taken by staff from the assisted dining room and placed in the hallway outside of her room. At 9:10 A.M., the resident was taken in her Broda chair by the Activity Director for a walk in the hallway. At 9:15 A.M., the Activity Director brought the resident back to her room and placed the resident in the hallway outside of her room where she remained until 10:22 A.M. when the Activity Director assisted the resident in her Broda chair to the dining room for an activity. At 11:09 A.M., the resident was assisted by the Activity Director from the main dining room into the assisted dining room. The resident remained in the assisted dining room until 1:15 P.M. At 1:15 P.M., the resident was propelled in her Broda chair by a CNA and placed in the hallway outside of her room. From 1:15 P.M. to 3:15 P.M., the resident remained outside of her room in the hallway seated in her Broda chair. At no</p>			

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	<p>time was the resident observed to be checked or changed. At 3:20 P.M., CNA #25 was questioned if the resident ever lays down in the afternoon the CNA indicated "sometimes." At 3:25 P.M., CNA#25 and CNA#26 assisted Resident #31 into bed with the use of the hooyer lift. As the resident was lifted from her Broda chair there was a strong foul smelling urine odor, the pressure relieving cushion in the Broda chair was wet, the resident's light tan slacks had a large wet stain on the back of them. The brief was saturated with a strong foul smelling urine odor, the resident had a moderate amount of soft brown bowel movement in the brief. A Mepilex dressing to the coccyx area was wet with urine and the dressing was coming off of the coccyx area. LPN (Licensed Practical Nurse) #27 came into the room to remove the soiled dressing to the coccyx and apply a new dressing. LPN #27 indicated the resident had a pressure area on her coccyx but it was healed now the dressing continues to the area for protection. The skin to the coccyx was observed no open areas was observed.</p> <p>During an interview, on 3/9/16 at 3:30 P.M., CNA #26 indicated she works the evening shift and receives report from the day shift before they leave for the day. She indicated the resident should have</p>			

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	<p>been changed before and after lunch because she is a check and change every 2 hours and as needed.</p> <p>On 3/10/16 at 10:00 A.M., RN (Registered Nurse) #20 provided a policy titled "Bladder Incontinence Program," dated 5/2006, and indicated the policy was the one currently used by the facility. The policy indicated "...Bladder Assessment...4. Once the form is completed, the MDS Coordinator will add the appropriate bladder program to the resident's plan of care, nursing assistant assignment sheets, and other relevant documents, such as ADL [Activities of Daily Living] sheets, restorative nursing forms, & 24 hour report form to assure staff knowledge and follow through...5...Reassessment will occur at least quarterly after that, as indicated by the resident's condition and the outcome of the bladder program...."</p> <p>During an interview, on 3/14/16 at 10:44 A.M., the Director of Nursing indicated the resident should be checked and changed after each meal, at HS and as needed. She further indicated she was unsure why a bladder assessment had not been completed on this resident. She indicated the MDS nurse should have completed it to correlate with the 1/5/16 MDS assessment. She indicated the</p>			

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	<p>quarterly update should be on the back of the bladder assessment and the assessment should be on the paper chart.</p> <p>B. 2. A clinical record review was conducted on 3/9/2016 at 8:53 A.M., and indicated Resident "I" was admitted on 10/27/2015. The clinical record indicated the diagnoses included but were not limited to: chronic obstructive pulmonary disease, arteriosclerosis of autologous artery coronary artery bypass graft with other forms of angina pectoris, major depressive disorder recurrent mild anxiety disorder, age related osteoporosis without current pathological fracture, edema, insomnia, muscle weakness, and mood disorder due to known psychological condition with depressive features.</p> <p>A MDS (minimum data set) completed on February 2, 2016, indicated Resident "I" had a decline in bladder continence.</p> <p>There was no documentation available related to a bladder assessment or care plan for Resident "I's" current bladder needs.</p> <p>During an interview on 3/9/2016 at 9:34 A.M., the DON (Director of Nursing) indicated that Resident "I" should have had a bladder assessment completed,</p>			

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	<p>however she was unable to locate a completed bladder assessment for Resident "I".</p> <p>On 3/10/2016 at 10:00 A.M., the Copporate Nurse provided a policy titled "Bladder Incontinence Program," dated May 2006, and indicated this was the policy currently used by the facility. The policy indicated "...POLICY: Any resident identified as incontinent of urine will be evaluated for causal factors and appropriate actions will be undertaken to obtain the most effective results, depending on the source and cause of the incontinence. Management strategies will be utilized and might include toileting programs, used of prescribed medications, fluid and dietary management, exercise, external collection devices, environmental modifications, and use of absorbent products. The choice of intervention will be dependent on assessment findings. See "Treatment Pathway for Incontinence" directly behind this policy/procedure, which includes a description of the available toileting programs in this facility...." and "...A number of factors may contribute to the decline or lack of improvement in urinary continence, for example: underlying medical conditions, an inaccurate assessment of the resident's type of incontinence (or lack of</p>			

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F 0318 SS=D Bldg. 00	<p>knowledge about the resident's voiding patterns) may contribute to inappropriate interventions or unnecessary use of an indwelling catheter. Facility practices that my promote achieving the highest practicable level of functioning, may prevent or minimize a decline or lack of improvement in degree of continence include providing treatment and services to address factors that are potentially modifiable, such as:...."</p> <p>This Federal tag relates to Complaint IN00193960.</p> <p>3.1-41(a)(1) 3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review the facility failed to provide contracture care to Resident #9. This deficient practice had the ability to</p>	F 0318	It is the policy of this facility to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase her range of	04/15/2016	

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	<p>affect 1 of 3 residents reviewed for contracture care. (Resident #9)</p> <p>Findings include:</p> <p>A clinical record review was completed on 3/10/2016 at 11:11 A.M., for Resident #9. Resident #9 was admitted on 6/19/2014. The diagnoses included, but were not limited to: nontraumatic intracerebral hemorrhage and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, hemiplegia unspecified abnormalities of gait dominant side, muscle weakness, anxiety disorder, abnormalities of gait and mobility and convulsions.</p> <p>There was no documentation available related to care plan for the use of splint devices or ROM (range of motion) exercises for Resident #9's contracture to her right arm. There was also no documentation available related to a refusal care plan indicating Resident #9 refused a splint or ROM exercises for her right arm.</p> <p>During an interview on 3/7/2016 at 3:14 P.M., Nurse #2 indicated Resident #9 had a contracture to her right arm due to a stroke. She further indicted she was unsure if Resident #9 received any ROM (range of motion) exercise or had any</p>		<p>motion and/or to prevent further decrease in range of motion, including provision of contracture care. 1. <u>What corrective action will be done by the facility?</u> Resident #9's care plan has been updated to reflect her consistent choice not to wear a splint on her right arm or to have ROM to her upper body. There will be a modification done to the 3/9/16 MDS to accurately reflect the fact that she is unable to move her right arm. Nursing staff will be in-serviced on the need for splints and ROM for residents who have contractures or are otherwise unable to move one of their extremities. They will also be in-serviced on informing the DON or charge nurse if a resident refuses the use of these other devices/modalities. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents with contractures have the potential to be affected by this practice. The DON and Nurse Consultant have checked other residents who currently reside in the facility who have contractures. No other issues have been identified at this time related to contracture care. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> If the DON or other IDT member finds that a resident has a contracture or other lack of mobility in one of his/her</p>				

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	<p>splint devices in place.</p> <p>During an interview on 3/11/2016 at 11:24 A.M., the DON (director of nursing) indicated Resident #9 should have a care plan addressing her refusal of any type of treatment to her right arm. She indicted Resident #9 was unable to move her right arm and the MDS (Minimum Data Set) should reflect this, however it does not. She indicated Resident #9s' care plan is not reflective of the residents needs.</p> <p>On 3/9/2016 at 8:49 A.M., Resident #9 was observed to be sitting in her bed without the use of a splint.</p> <p>On 3/10/2016 at 11:29 A.M., Resident #9 was observed with her right arm at her right side. No movement of her right arm was observed.</p> <p>On 3/14/2016 at 10:45 A.M., the Coporate Nurse provided a policy titled "Prevention of Pressure Ulcers," dated January 2005, and indicated this was the policy currently used by the facility. The policy indicated "...CONTRACTURES: Contractures, which cause shortened and flexed positions of the affected area, develop in predictable patterns, so splinting, range of motion exercises, and proper positioning can help prevent their</p>		<p>extremities and does not have a splint or is not receiving treatment, such as ROM, the DON will talk with the resident and notify the therapy provider for evaluation of the resident's condition. If the resident declines the use of a splint or does not want to receive ROM or other type of treatment, that choice will be documented in the resident's record and in the resident's care plan. The therapy provider will conduct quarterly screens to see if any resident has changed in regards to his/her range of motion or if he/she is at risk for development of a contracture. Based on the outcome of that screen, the physician will be contacted for orders for further therapy evaluation and services if deemed necessary based on the screen results. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or other designated members of the IDT will bring the result of the therapy screens for contractures and/or range of motion to the weekly Standards of Care meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the DON and the results of those recommendations will be brought back to the next scheduled QA Committee meeting for review.</p>		

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F 0323 SS=E Bldg. 00	<p>occurrence. Such prevention is necessary not only because of the loss of strength and function they cause, but also because they may compromise positioning and hygiene. In addition, significantly contracted limbs are thought to result in impaired blood supply to that limb - which should raise a red flag, since pressure ulcer development has its origins in impaired blood flow and resultant tissue ischemia. Although a contracture will not necessarily result in a pressure ulcer, healing of a pressure ulcer that does erupt will be complicated by the poor perfusion of the limb...."</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure there was adequate supervision during dining for 1 of 3 meals observed. In addition, the facility failed to ensure chemical and razors were not assessable in 1 of 18 residents rooms and 1 of 4</p>	F 0323	<p>This will continue on an ongoing basis. Date of Compliance: 4/15/16</p> <p>The Administrator and IDT members have checked the resident rooms and care areas to make sure that all unsafe items have been removed or repaired as needed. The Administrator has assigned management staff to assist in supervising the dining room and to make sure that staff</p>	04/15/2016

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	<p>community resident bathrooms. Lastly, the facility failed to ensure fall interventions were implemented timely to prevent more falls for 1 of 3 residents reviewed for accidents. (Resident #30)</p> <p>Findings include:</p> <p>1. The closed clinical record for Resident "E" was reviewed on 03/11/2016 at 11:08 A.M. Resident "E" was admitted to the facility on 01/02/12 with diagnoses, including but not limited to: vascular dementia without behaviors, schizophrenia, muscle weakness, hypertension, hyperlipidemia, gastro-esophageal reflux disorder, enlarged prostate, constipation, pulmonary collapse, chronic gout, major depressive disorder, and chronic obstructive pulmonary disease.</p> <p>A nursing progress note, dated 02/07/16 at 23:00 (11:00 P.M.), indicated the resident was heard yelling "Help me I fell. " The resident was found in his room, lying in a prone position on floor by the other bed in his room. The resident had a laceration to his scalp. The resident informed the emergency medical transport staff he fell out of his bed but told the nurse he fell ambulating to the bathroom.</p>		<p>is monitoring all residents as they eat. If the Administrator or any IDT member identifies a concern in any of these areas, he/she will make sure that the resident remains safe while the issue is removed or fixed. Once the resident's welfare is met, the Administrator or manager overseeing the area of noncompliance will address the staff involved by re-training them in regards to the facility policy. In addition, progressive written counseling will be rendered for continued noncompliance.</p> <p>1. <u>What measures will be put into place to ensure this practice does not recur?</u> The DON will bring any resident who has fallen to the next scheduled IDT morning management meeting which meets at least 5 times per week for review of the incident by the IDT members. The circumstances of the fall will be discussed by the IDT and the resident's care plan will be reviewed for appropriate interventions to prevent future falls. Any change in interventions will be dated to show when each was added, deleted, or revised. The CNA assignment sheets will be updated as well at that time to include any changes in the interventions for the resident. The Nurse Consultant will review the care plans of residents who have experienced a fall since her last visit to make sure that the care plans are current and will</p>		

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	<p>A fall assessment form, completed on 02/07/16 and revised on 02/17/16, indicated the resident was oriented, had gait issues, was utilizing a walker, had pain issues and poor lighting when he fell. There were no recommendations noted on the fall investigation form.</p> <p>A Morse Fall Scale assessments for Resident "E," completed on 02/08/16, indicated he scored a 70 which corresponded with high risk for falls.</p> <p>A nursing progress note, dated 02/09/16 at 2:05 A.M., indicated Resident "E" was heard yelling "Help" at 12:30 A.M. and was found lying in the hallway by the bathroom. The resident had no visible injuries and he was assisted to walk with his walker back to his room. A audible alarm was placed on the resident.</p> <p>A care plan related to fall risk, initiated on 12/31/15, indicated there were no interventions implemented to prevent further falls after the resident fell on 02/07/16.</p> <p>During an interview with the Director of Nursing, on 03/15/16 at 3:30 P.M., she indicated the resident was to utilize and wheelchair and was to be working with therapy. She indicated his walker was left in his room, the care plan was not</p>		<p>re-train the IDT members for any that she finds out of compliance. The Nurse Consultant will visit the facility at least weekly for the next 60 days, then at least twice a month from that point on to ensure regular follow up. **** Issues that are identified in any of these areas will be addressed as indicated in question #2. 3. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> In addition to the IDT morning management meeting, residents who have fallen and the resulting interventions for fall prevention will be reviewed by the IDT at the weekly Standards of Care meeting. Changes in interventions will be done at that time for any identified issues. The DON/designee will audit these issues utilizing the Physical Environment Audit, the Dining Observation Audit and the F323 Falls Audit 5 times a week for 30 days, then twice a week for 30 days and weekly ongoing. She will report her findings in the monthly QA meetings. The DON will discuss the residents who have fallen and the interventions that have been put into place at the monthly QA Committee meeting for further review and recommendation from the members. In addition, the Administrator or designee will bring the results of the written audits to the weekly Standard of</p>		

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	<p>updated and he did fall again on 02/09/16. She indicated once the resident's walker was removed from his room he did not attempt to get up out of bed by himself anymore.</p> <p>2. On 3/9/16 at 8:15 A.M. thru 8:18 A.M., the main dining room was observed to have no staff in it. And again at 8:30 A.M., the main dining area was observed to have no staff available to the residents. At 8:32 A.M., LPN (Licensed Practical Nurse) #3 returned to her medication cart, which was in the hallway facing into the main dining area, but was approached by the Activity Director who was showing her pictures. They talked and discussed the photos. There were 15 residents in main dining area and 7 residents in side room dining area during the observations from 8:15 A.M. thru 8:32 A.M. CNA (Certified Nursing Assistant) #5, CNA #71 and CNA #70 were in the side dining room assisting some of the residents, however CNA #5 and CNA #70 had their back to the main dining area, and CNA #71 was facing the main dining area and indicated she could only observe 4 residents from her position in the side dining area. A physical therapist came and went from the side dining area as breakfast was being served. The side dining area had a television on and none of the CNA's</p>		Care and monthly QA Committee meetings for review. If any recommendations are made in any of these areas, the designated person will follow up and report the results of the recommendations back to the QA committee at the next month's meeting. This will continue on an ongoing basis. Date of Compliance: 4/15/16		

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	<p>looked up or over into the main dining area when a resident coughed from the main dining area.</p> <p>3. On 3/10/16 from 2:00 P.M. to 2:30 P.M., an environmental tour was conducted of the facility with the Maintenance Director, the Housekeeping Supervisor, and the Administrator, during which the following was observed:</p> <p>At 2:00 P.M., Resident Room 2 bed 2 was observed with a call light plugged into the wall receptacle, the call light functioned properly when tested and was observed on top of the resident's pillow. The call light cord was observed to be pulled away from the end of the call light case, this exposed two rubber coated cords.</p> <p>During an interview, on 3/10/16 at 2:02 P.M., the Maintenance Director indicated he checks call lights daily and the call light would be replaced immediately.</p> <p>At 2:05 P.M., the community resident restroom #2 was observed to have a 32 ounce bottle of Derma Tech shampoo body wash and a large pump bottle of skin care cream on the floor of the bathroom.</p> <p>During an interview, on 3/10/16 at 2:06</p>			

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	<p>P.M., the Administrator indicated no chemicals should be left out and these items should have been locked in a cabinet.</p> <p>At 2:08 P.M., Resident Room 6 bed 1 was observed to have a bottle of bodywash on top of a 3 drawer dresser located beside the sink in the room.</p> <p>At 2:20 P.M., Resident Room 7 had a 32 ounce bottle of mouthwash, a tube of denture adhesive and a tube of toothpaste located on a stand beside the sink in a shared room.</p> <p>At 2:25 P.M., Resident Room 9 bed 2, a disposable metal razor was observed on top of the sink in a shared room.</p> <p>During an interview, on 3/10/16 at 2:26 P.M., the Administrator indicated a disposable razor should not be left out in case a confused resident would wander into the room.</p> <p>At 2:28 P.M., Resident Room 10 bed 1 (Resident #9) and bed 2 (Resident #28), each side of the room was observed to have a 10 cup coffee pot maker with a glass carafe.</p> <p>During an interview, on 3/10/16 at 2:45 P.M., the Administrator indicated she</p>			

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F 0329 SS=D Bldg. 00	<p>was unsure if a safety assessment had been conducted on Resident #9 and Resident #28 to ensure they were safe to use the coffee pots she further indicated she would check into it.</p> <p>During an interview, on 3/10/16 at 4:30 P.M., RN (Registered Nurse) #20 indicated a safety assessment had not been completed on Resident #9 or Resident #28 in Room 10 to ensure they were safe to use a coffee pot. She further indicated coffee pots and microwaves are not allowed in the resident rooms so the coffee pots had been removed.</p> <p>This Federal tag relates to Complaint IN00193960.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse</p>			

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	<p>consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interviews, the facility failed to ensure adequate monitoring regarding the presence of continued adverse side effects for 1 of 6 residents reviewed for unnecessary medications (Resident #3) and targeted medical symptoms for 1 of 6 residents reviewed for unnecessary medication. (Resident #25)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed on 03/11/2016 at 10:20 A.M. Resident #3 was admitted to the facility on 09/29/05, with diagnoses, including but not limited to: intellectual disabilities, schizoaffective disorder and dementia without behavioral disturbances.</p> <p>The current physician's orders for</p>	F 0329	<p>It is the policy of this facility to ensure adequate monitoring regarding the presence of continued adverse side effects and targeted medical symptoms.</p> <p>1. <u>What corrective action will be done by the facility?</u> Resident #3's medication was reviewed by the Behavior Committee and a recommendation was made to decrease his Clozapine from a total of 150 mg. per day to a total of 100mg. per day on 3/25/16. The physician was notified on 4/6/16 that the resident continued to be lethargic at times and was drooling. There were no new orders obtained at that time. On 4/8/16 the facility notified the physician of the same issue – an order was received for Resident #3 to be seen by psych services on 4/24/16. Resident #25's medication was reviewed by the Behavior Committee and a recommendation was made to</p>	04/15/2016

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	<p>medications included the following medications utilized to address the resident's psychiatric and behavioral needs:</p> <ul style="list-style-type: none"> *Medroxyprogesterone Acetate 10 mg (milligrams) every evening for inappropriate sexual behaviors *Divalproex Sodium 500 mg one table in the evening due to schizoaffective disorder *Clozapine 50 mg one tablet in the evening and 100 mg in the am for schizoaffective disorder <p>Resident #3 was observed, on 03/08/16 at 10:30 A.M., in the dining room seated in his wheelchair with his head down and was visibly drooling onto his shirt front. The resident was greeting and attempted to speak but a large amount of saliva drooled out of his mouth and after briefly looking up, he immediately fell back to sleep.</p> <p>Resident #3 was observed, on 03/10/16 at 11:45 A.M., seated in the dining room/lounge sleeping in his wheelchair while activities were being conducted. The resident was noted to be drooling and was very lethargic. The Activity Director was notified and she attempted to arouse the resident and then when she realized he was barely arousable she took him to his room where two nursing</p>		<p>decrease her Seroquel from 50 mg. per day to 25 mg. per day on 3/25/16. The nurses will be in-serviced by the Nurse Consultant and DON regarding the need to document each shift on the Side Effects monthly flow sheet to clearly indicate when any resident is experiencing side effects from the medication that he/she is taking. The entire staff will be in-serviced by the Administrator and SSD on using, reading, and documenting on the behavior logs by 4/15/16. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Residents taking medications, including psychoactive medications, have the potential to be affected by this practice. If the DON, Administrator, SSD or other IDT members observe that a resident may be experiencing side effects from the medication that he/she is taking, the DON(if not already aware) and Charge Nurse will be notified immediately, so that the resident can be assessed and the physician notified of any changes in condition. If the DON, SSD, or Administrator finds that the documentation on the behavior logs and side effect sheets is not complete or accurate, the DON and/or the SSD will address those issues with the staff involved. There will be progressive disciplinary action rendered, as</p>		

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	<p>assistants tried to arouse him. The Director of Nursing was notified and eventually checked his blood sugar which was 262 mg/dl. All of the staff indicated the resident was found in this condition on an almost daily basis.</p> <p>Resident #3 was observed, on 03/11/2016 at 10:15 A.M., sleeping in the front of the facility by the front doors. The resident had his head down and eyes closed and was visibly drooling on his shirt front. There was a large soccer ball sized wet spot on his shirt. The resident was holding a glass of brown colored liquids and almost spilt it on himself. He was awakened and with continued verbal cues and conversation, did wake up and spooned his liquid into his mouth but drooled and dribbled some down his chin and onto his shift front. He started coughing with the liquids initially but then fell back asleep.</p> <p>LPN (Licensed Practical Nurse) #50 was interviewed on 03/14/2016 at 11:09 A.M. She indicated she had noticed the drooling increasing lately and she had notified the Nurse Practioner on 02/25/16, and the nurse practioner had discontinued a Scopalamine patch. (Scopalamine is a medication utilized to treat motion sickness, nausea and vomiting with adverse side effects,</p>		<p>well, for continued noncompliance in any of these areas. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The SSD and the Administrator will review all residents' behavior logs and care plans, including the interventions which are in place, to make sure that they are specific and current to the residents' status by 4/15/16. In addition, the SSD will bring the behavior logs and care plans to the IDT morning management meeting which occurs at least 5 days a week for review of new or persistent behaviors that have occurred. The IDT will make recommendations for changes in interventions as needed. The SSD will post any intervention changes on the 24 hour report for communication to the staff and all shifts. The DON will update the CNA assignment sheet, too, as needed. The DON/designee will review the Side Effects Monitoring Flow sheet for completion and accuracy 5 times a week for 30 days, then twice a week for 30 days then weekly ongoing and bring her findings to the monthly QA committee.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The SSD will bring the results of the Behavior Committee meetings and behavior logs' reviews to the monthly QA Committee for further review. The DON will bring the</p>		

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	<p>including but not limited to: increased confusion, drowsiness and dry mouth.) LPN #50 indicated she had worked at the facility for the past 5 months and Resident #3 had been noted to drool and often slept. She indicated the resident was able to be aroused.</p> <p>A Weekly summary assessment, completed on 03/05/16, indicated the resident was alert, unsteady with impaired balance and had deteriorating AdL function and was requiring more assistance, and had no changes in this mood and behavior.</p> <p>An AIMS (Abnormal Involuntary Movement Scale) assessment, completed on 02/26/16, indicated the resident scored a 0 and had no involuntary movements.</p> <p>A Nutrition/Dietary note, completed on 02/22/16, indicated the resident was coughing while eating and even when he was not eating he has been drooling a lot.</p> <p>A 02/11/16 Psychosocial note - Behavior/medication meeting, conducted on 02/10/16, indicated there had been no new recommendations and the resident had no concerns. The note indicated the resident's medications and behavior program were to be continued.</p>		<p>results of her audits to the monthly QA Committee, as well. Even though the QA Committee may decide to stop requiring paper audits, the SSD and DON will continue the process as outlined in #3 on an ongoing basis.</p>		

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	<p>The February and March Side Effects monthly flow sheet, indicated only the evening shift had consistently documented on the form and all of the documentation indicated "29." The code for the form indicated "29" was utilized to documented "none" regarding adverse side effects.</p> <p>Although staff verbalized and confirmed the resident had been drooling excessively and was not always alert, the adverse side effects documentation was inaccurate and other than calling on 02/25/16 and notifying the physician, there was no accurate monitoring of the resident.</p> <p>2. The clinical record for Resident #25 was reviewed on 03/10/2016 at 9:13 A.M. Resident #25 was admitted to the facility on 02/13/14 with diagnoses, including but not limited to: vascular dementia with behavioral disturbance, cerebralvascular disease, anxiety disorder, major depressive disorder and psychosis.</p> <p>The current physician's orders for medications included the following: Seroquel (an antipsychotic medication) 50 mg one tablet in the evening for Atypical Psychosis and Aricept (a medication to treat dementia) 10 mg in</p>			

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	<p>the evening- dementia with delusions.</p> <p>The Behavior Monitoring Record for Resident #25 indicated she was to be monitored by Dementia with agitation evidenced by stripping out of clothes and refusing care and getting confused and wanting to go home to her children and exit seeking. It was unclear which medical symptoms required the use of the Seroquel medication diagnosed as "Atypical Psychosis."</p> <p>The current health care plan regarding antipsychotic medication use, current through April 2016, denoted the resident had a diagnosis of Atypical psychosis and Vascular Dementia with delusions and behaviors. The plan did not indicated how the resident displayed delusions or what specific behaviors were included in the care plan.</p> <p>Another current plan indicated the resident had a diagnosis of Atypical Psychosis. The plan indicated in the past, when gradual dose reductions were attempted for the resident's Anti-psychotic medication, Seroquel, she had exhibited increased confusion and became anxious. She attempted to exit the building to get home to her children and husband, became agitated with staff, and stripped out of her clothes and</p>			

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	<p>refused staff assistance.</p> <p>The Behavior Monitoring records, from August 2015 through March 2016, indicated there was no documentation of any behaviors on the form. The nursing progress note indicated a late entry note, entered on the electronic nursing progress notes on 03/14/16 at 14:08 (2:08 P.M.) indicated on 03/12/16 at 14:06 (2:06 P.M.), Resident #25 had been "going through hallways saying that she need to get out of here and go home. Attempted re-direction several times. Resident continued to be anxious and insisting that she needed to go home." It was unclear if the Administrator, who entered the behavior note, tried any more the interventions on the behavior plan other than redirection.</p> <p>A psychiatric nurse practioner note, completed on 02/10/16, regarding the Seroquel medication use indicated the resident had a failed dose reduction of the medication and was "kicking doors, picking/digging her skin and refusing care...." The note also indicated "...she continued to have behaviors but they are much less distressful and she is easily redirected with 1 on 1...." It was unclear where the nurse practioner obtained her information as there had been no behaviors documented on the monitoring</p>			

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	<p>form since at least August 2015. In addition, picking/digging her skin and kicking doors were not being monitored.</p> <p>During an interview, on 03/10/2016 at 10:11 A.M., CNA #54 indicated she was not aware of any specific behavior management plan for Resident #25. She indicated she had not had Resident #25 demonstrate any behaviors while she was working with her. She indicated the resident was always cold and needed a blanket and sometimes was too sleepy to toilet but no other behaviors.</p> <p>During an interview, on 03/10/16 at 2:45 P.M., CNA #52 indicated she was not aware of any behavior monitoring for Resident #25. She indicated sometimes she would wake up and think she had to go get her kids to bed but that was all she had ever displayed. CNA #52 indicated she had not documented any behaviors on the monitoring forms for Resident #25.</p> <p>Resident #25 was observed, on 03/08/16 during the morning hours between breakfast and lunch, seated in her wheelchair, just outside her room door in the hallway covered with a blanket. She was noted to sleep in her wheelchair most of the day. She was not observed to attempt to exit the building, remove her clothing, and was not heard verbalizing</p>			

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	<p>any delusional thinking such as needing to go home or see to her children.</p> <p>An undated policy and procedure, titled "Psychoactive Drug Monitoring" was provided on 03/15/16 at 10:00 AM. by the nursing consultant, RN (Registered Nurse) #55. The policy included the following: "Residents who receive antidepressant, hypnotic, antianxiety, or antipsychotic medications are monitored to evaluate the effectiveness of the medication. Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with the minimum of untoward's effects...Antipsychotics: 2. Residents receive antipyretic medication only for behaviors that are quantitatively and objectively documented through the use of behavior monitoring charts or a similar mechanisms....7. Residents who are receiving antipsychotic drug therapy are adequately monitored for significant side effects of such therapy, through the use of the AIMs and other appropriate tests...."</p> <p>3.1-48(a)(6)</p>			

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F 0332 SS=E Bldg. 00	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent (%) for 4 of 7 residents observed during medication pass. Four (4) medication errors were observed during 31 opportunities for error in medication administration. This resulted in a medication error rate of 12.9 percent. The errors involved 4 residents (Resident #6, #27, #34 and #8) in a sample of 7.</p> <p>Findings include:</p> <p>1. On 3/9/16 at 7:56 A.M., Resident #6 was observed being administered 5 units of Humalog (fast acting insulin) by subcutaneous injection by LPN (Licensed Practical Nurse) #3. After the injection the resident was observed propelling himself toward the dining room. He positioned himself at 8:08 A.M. in front of a table at the place he would usually sit. The resident's table had a plastic cup with juice in it, however the lid had a small opening for a straw and there was no straw placed in the cup for the resident.</p>	F 0332	<p>It is the policy of this facility to ensure that medications are given as ordered and without error.</p> <p>1. <u>What corrective action will be done by the facility?</u> When notified of the issue with timing of insulin administration and meal service to those residents who receive fast acting insulin, the facility immediately changed their practice and made sure that residents receiving insulin were also given sugar free pudding to eat before being taken to the dining room for their breakfast. All nurses were in-serviced at that time by the DON to offer sugar free pudding to all residents receiving fast acting insulin before being taken to the dining room for breakfast. In addition, the DON and Nurse Consultant will re-train all nurses in that practice once again, as well as making sure that residents have the assistive devices needed to eat or drink, and that residents who are slow to respond during meal time, especially those who are diabetic, will be checked by the nurse and will be offered assistance to eat or drink, so that he/she can consume the meal. The nurses will also be in-serviced on making sure that items such as eye drops, liquids,</p>	04/15/2016			

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	<p>During an interview, on 3/9/16 at 8:21, LPN #3 indicated the resident needed a straw to drink his juice as resident was a choking risk.</p> <p>On 3/9/16 at 8:34 A.M., Resident #6 took his first bite of food, and straws were placed in his juice at 8:37 A.M.</p> <p>2. On 3/10/16 at 11:55 A.M., Resident #27 received Novolog (fast acting insulin) 15 units by subcutaneous injection. At 12:06 P.M., the resident was propelled to the dining room by a CNA (Certified Nursing Assistant) in his wheelchair and placed in front of a table. The resident's eyes were closed. The Social Service Director was observed placing the resident's lunch in front of him soon after he arrived at the table. The Social Service Director was observed walking away from the resident as soon as she placed the meal tray in front of him. The Social Service Director did not attempt to awaken the resident or ask him what he wanted to drink. At 12:19 P.M., LPN #3 was observed trying to awaken the resident, she asked for grape juice to be brought to the resident. LPN #3 attempted to have the Resident drink some juice. LPN#3 asked the resident to open his eyes and take a drink, and the resident responded and took several sips of the juice. LPN #3 then fed the resident</p>		<p>topicals, and other medications that are not automatically refilled by the pharmacy, are ordered from the pharmacy in enough time to prevent the residents from doing without them. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice. If the DON or other member of the IDT observes any resident who is drowsy or having some difficulty in eating, he/she will notify the charge nurse, so that the resident may be assessed and assisted as needed. If the DON finds that medications are not available to give to residents, she will follow up with the charge nurse and pharmacy to find out what the issue is and resolve it. Once these concerns are taken care of, the DON will re-train the staff involved in both situations if she has found that the staff did not follow facility policy in either case. Once that is done, she will also render progressive disciplinary action for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u>The DON/designee will audit for assistive devices utilizing the Dining Meal Audit Tool 5 times a week for 30 days, the twice a week for 30 days and weekly ongoing and report her findings to the monthly QA</p>		

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	<p>a few bits of potatoes and the resident opened his eyes and completed his meal.</p> <p>During an interview, on 3/10/16 at 12:22 P.M., the Social Service Director indicated she was unaware of which residents in the dining area were obtaining insulin injections prior to their meal. She indicated she had started at the facility 2 weeks ago.</p> <p>During an interview, on 3/10/16 at 12:30 P.M., LPN #3 indicated a resident who received fast acting insulin should eat or drink within 15 minutes.</p> <p>On 3/10/16 at 2:25 P.M., the Director of Nursing provided a policy titled, "Medications-General Policies," revised on 5/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...Fast acting insulin, such as Novolog or Humalog, will be administered within 15 of the scheduled meal time..."</p> <p>3. On 3/10/16 at 10:03 A.M., during a morning medication pass Resident #34 did not receive his Refresh Tears Solution 0.5% instill into his right eye as ordered. LPN #3 indicated there was no Refresh Tear medication available for the resident's morning pass.</p>		<p>Committee meeting. The DON/Designee will audit the use of sugar-free pudding/equivalent 5 times a week at random medication passes and document her findings on the Medication Review Audit Tool and report her findings to the monthly QA Committee Meeting monthly.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the result of her audits and observations to the weekly Standards of Care meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the DON and the results of those recommendations will be brought back to the next scheduled QA Committee meeting for review. This will continue on an ongoing basis. Date of Compliance: 4/15/16</p>				

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	<p>A review of the Medication Administration Record (MAR) indicated Refresh Tears Solution was to be instill into the resident's right eye three times a day. The MAR indicated the resident did not receive the Refresh Tears (3 doses) on 3/10 and 3/11 the A.M. dose (one dose). The medication was received on 3/10/16 for the afternoon dose.</p> <p>4. On 3/10/16 at 10:30 A.M., during an A.M. medication pass Resident #8 did not receive her Miralax (Laxative) 17 grams by mouth in the morning as ordered. LPN #3 indicated there was no Miralax available for the resident's A.M. morning dose.</p> <p>A review of the resident's MAR indicated the resident did not receive her daily morning dose of Miralax on 3/10/16, and received her morning dose on 3/11/16.</p> <p>On 3/11/16 at 2:30 P.M., the Director of Nursing provided a policy titled "Medication Ordering and Receiving," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...b. Repeat medications (refills) are written on a medication order form/ordered by peeling the top label from the medication or treatment and placing it in the appropriate area on the reorder form provided by the pharmacy</p>			

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F 0334 SS=D Bldg. 00	<p>for that purpose and ordered as follows: *Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand...."</p> <p>3.1-25 (b)(9) 3.1-48(c)(1)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p>				

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	<p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review the facility failed failed to obtain a consent</p>	F 0334	It is the policy of this facility to obtain consent or declination for the influenza and Pneumovax	04/15/2016			

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	<p>for the influenza vaccine prior to administration or declination of the vaccine and failed to obtain a consent for a Pneumovax administered on 10/15/2014. This deficient practice affected 3 of 5 residents reviewed for immunizations. (Residents "B", #17 and #25)</p> <p>Finding includes:</p> <p>During a record review on 3/15/2016 at 12:00 P.M., the following was noted: Unable to locate a Pneumovax consent for the Pneumovax vaccine administered to Resident #17 on 10/15/2014. Unable to locate a consent for an influenza vaccination administered to Resident #25 on 11/18/2015. Unable to locate any documentation that the facility offered an influenza vaccination for the 2015/2016 influenza season for Resident "B."</p> <p>During an interview on 3/15/2016 at 12:04 P.M., the DON (Director of Nursing) indicated that she was unable to locate the missing documentation or consents related to the immunizations for Resident #17, #25, or "B."</p> <p>On 3/15/2016 at 2:01 P.M., the administrator provided a policy titled "Immunization, Influenza,</p>		<p>vaccine before administering it to the resident. 1. <u>What corrective action will be done by the facility?</u> The DON and Nurse Consultant will in-service all nurses regarding the facility policy for obtaining consent or declination from residents or their legal representatives prior to administering either the influenza or pneumovax vaccines. The Nurse Consultant will in-service the DON on using the Immunization Report that is available on the electronic medical record system to track all residents consents, declinations, refusals, and administration of vaccines, including the influenza and pneumovax. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice. The DON and Nurse Consultant will review all resident's records to make sure that each one has consents or declinations evident for the influenza and pneumococcal vaccines. If any are found missing, the DON or designee will contact the resident or legal representative to obtain either a consent or declination – whichever is not available in the resident's chart. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The DON will check all residents' status as far as</p>				

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	<p>Pneumococcal, & Variceila Vaccines," dated April 2003, and indicated that this was the policy currently used by the facility. The policy indicated "...6. Once the education has been completed and all questions answered, the resident or legal representative will be asked to sign the "Influenza Immunization Education and Informed Consent" form, which gives consent for the admission influenza immunization as well as all future flu immunizations that her administered each year from October 1st to March 31st, or at a frequency recommended by the Centers for Disease Control & the resident's personal physician. The signed consent/declination from will be maintained on the resident's medical record..." and "...Annual Review: 2. Regardless of whether a resident or legal representative has consented or declined prior years' immunizations, all residents will be offered the influenza immunization each year and will receive education concerning the influenza vaccination before receiving the vaccine, unless there is a documented contraindication..."</p> <p>3.1-13(a)</p>		<p>consents, declinations, refusals, and administration of vaccines on the electronic medical records system at least monthly. In addition, the DON or MDSC will review the status of residents who are newly admitted with the IDT at the morning management meeting first scheduled after a resident's admission. As part of this review, the IDT will check to see if there are appropriate consents for the influenza and/or pneumovax vaccines. They will also check to see if the vaccine has been administered, if appropriate at that time. If not yet administered due to availability or because of the time of year, the DON will monitor the immunization report for completion of the administration when scheduled. If consents are not available, the DON or SSD will follow up with the resident or legal representative to obtain their written consent/declination. An audit was completed of all residents for consents or declination of Flu or Pneumovax. Any resident requiring pneumovax vaccinations and having a consent will receive the vaccination as ordered. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will report the status of immunizations at the interdisciplinary Standards of Care meeting weekly and to the QA Committee at the monthly</p>		

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F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food was stored, served and prepared in a sanitary manner in 1 of 1 kitchen and 1 of 1 nourishment refrigerators. This potentially affected 34 of 34 residents who consumed food in the facility. (Employee #24)</p> <p>Findings include:</p> <p>On 3/7/16 from 9:45 A.M. to 10:15 A.M., the initial kitchen tour was conducted with the Dietary Manager and the following was observed:</p> <p>A stainless steel metal cabinet that was used as the food prep area had a dried white and brown substance splattered on</p>	F 0371	<p>meeting. Any further recommendations made will be followed up by the DON, who will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis. Date of Compliance: 4/15/16</p> <p>The facility does ensure food is stored, served and prepared in a sanitary manner. 1. <u>What corrective action will be done by the facility?</u> The stainless steel cabinet, 3 drawer Rubbermaid container containing utensils and the nourishment refrigerator have been cleaned will be added to the daily cleaning schedule. The nourishment refrigerator was immediately cleared of any outdated food/beverage. The 3 shelf stainless steel serving cart used for delivering drinks and condiments during meal service will be replaced with a new one and added to the daily cleaning schedule. Cook #24 was immediately in-serviced on correct handwashing procedures proper dishware handling. 2. <u>How will the facility identify other residents having the potential to</u></p>	04/15/2016	

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	<p>both sides of it.</p> <p>A three drawer Rubbermaid container containing utensils was located under the counter beside the dishwasher. Observed in the top drawer was a large metal fork and a metal pair of thongs both had a thick yellow sticky substance on them. The utensils had been put away as clean.</p> <p>A nourishment refrigerator was observed to have 1 box of opened nectar thick apple juice dated 5/21/15 with an expiration date of 11/11/15. One box of opened nectar thick apple juice dated 10/11/15 with an expiration date of 2/11/16. Four unopened bottles of slim rite with no name, the expiration date on each bottle was 2/23/16. One glass of milk with plastic wrap over the top of it with no name or date on it.</p> <p>During an interview, on 3/7/16 at 10:20 A.M., the Dietary Manager indicated it is the nursing staff responsibility to clean the nourishment refrigerator, make sure the food and drinks are dated and they should throw away expired items. She further indicated the Dietary staff check the temperatures of the refrigerator and freezer and stock the refrigerator with snacks and drinks needed for the residents. She indicated any item that has been opened and in the refrigerator more</p>		<p><u>be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected. All dietary staff to be in-serviced by the Dietary Manager on facility policy and procedure for equipment cleaning schedules, Dishwashing procedures, Date Marking, Hand washing/Alcohol-Based hand rub , Employee sanitary practices. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Dietary Manager will monitor daily for compliance and will initiate a weekly sanitation audit. If she finds or identifies any issue, she will correct it immediately and re-train the staff involved. She will also render progressive disciplinary action for continued non-compliance. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Weekly sanitation audits will be brought to the Weekly Standards of Care meeting and to QA monthly for 3 months, Once 100% compliance is achieved the QA committee may decide to stop them; however monitoring by the Dietary Services Manager and IDT members will continue as indicated on an ongoing basis. Date of completing: 4-13-16</p>		

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	<p>than 3 days should be thrown away.</p> <p>On 3/7/16 from 12:00 P.M. to 12:20 P.M. the following was observed in the kitchen during the noon meal service:</p> <p>At 12:08 P.M., Cook #24 was observed to wash her hands for 10 seconds then returned to the stove to continue serving food. Cook #24 was then observed to hold the plates with her bare thumb inside the plate where the food was located.</p> <p>On 3/9/16 at 11:20 A.M., a second kitchen tour was conducted with the Dietary Manager and the following was observed:</p> <p>A stainless steel metal cabinet that is used as the food prep area had a dried white and brown substance splattered on both sides of it.</p> <p>A three drawer Rubbermaid container containing utensils was located under the counter beside the dishwasher. Observed in the top drawer was a large metal fork and a metal pair of tongs both had a thick yellow sticky substance on them. The third drawer was observed to have various sized scoops, two scoops had a thick yellow sticky substance on this inside of them. The utensils had been put</p>			

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	<p>away as clean. The Dietary Manager took the contents out of the top and bottom drawer of the container and placed all of the items in the 2 compartment sink to re-wash them.</p> <p>Located in the hallway outside of the kitchen was a stainless steel serving cart with three shelves that was used for delivering drinks and condiments during the meal service. On the top shelf was a rubber shelf liner and several baskets filled with ketchup, mustard, salt and pepper. The 2nd and 3rd shelf was not lined with a rubber shelf liner. The second shelf had a rusty colored film on the back of it and dried white rings on the bare metal. The third shelf had dried white rings on the bare metal and a white string and hair hanging off the bottom edge of it.</p> <p>On 3/14/16 from 12:10 P.M. to 12:25 P.M., Cook #24 was observed during the lunch service reaching for the clean porcelain and plastic plates she was placing her bare fingers on the insides of all the plates to pick them up and then served the food portions onto the plates.</p> <p>At 12:26 P.M., a second observation was made of a stainless steel serving cart located outside of the kitchen in the hallway with three shelves that was used</p>			

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	<p>for delivering drinks and condiments during the meal service. On the top shelf was a rubber shelf liner and several baskets filled with ketchup, mustard, salt and pepper. The 2nd and 3rd shelf was not lined with a rubber shelf liner. The second shelf had a rusty colored film on the back of it and dried white rings on the bare metal. The third shelf had dried white rings on the bare metal and a white string and hair hanging off the bottom edge of it.</p> <p>During an interview, on 3/14/16 at 12:30 P.M., the Dietary Manager indicated the Cook that was serving the meal today was new and should not have handled the inside of the plates with her bare hands. She further indicated the serving cart that is in the hallway had recently been cleaned but it has permanent dried stains on it that she can't remove.</p> <p>On 3/14/16 at 1:00 P.M., the Dietary Manager provided a policy titled "Dishwashing Procedures," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Proper sanitation of dishware and dishware equipment is essential to prevent the spread of illness from one resident to another...5. Storage equipment must be washed and sanitized before clean dishes are stored. After each meal,</p>			

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F 0428 SS=D Bldg. 00	<p>equipment must be washed and sanitized...."</p> <p>On 3/14/16 at 1:05 P.M., the Dietary Manager provided a policy titled "Proper Food Handling," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...12. Utensils, cups, glasses and dishes must be handled in such a way as to avoid touching surfaces with which food or drink will come in contact...."</p> <p>3.1-21(i)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, record review and interviews, the facility failed to ensure pharmacy recommendations regarding psychoactive medications were addressed timely by the physician for 1 of 6</p>	F 0428	F428 It is the policy of this facility to ensure that pharmacy recommendations regarding psychoactive medications are addressed timely by the physician. 1. <u>What corrective action will be done by the facility?</u>	04/15/2016	

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	<p>residents reviewed for unnecessary medications. (Resident #3)</p> <p>Finding includes:</p> <p>The clinical record for Resident #3 was reviewed on 03/11/2016 at 10:20 A.M. Resident #3 was admitted to the facility on 09/29/05 with diagnoses, including but not limited to: diabetes, dysphasia, copd, combined heart failure, muscle weakness, hypothyroidism, hyperlipidemia, heart disease, constipation, intellectual disabilities, schizoaffective disorder, hypertension, and dementia without behavioral disturbances.</p> <p>The current physician's orders for medications included the following medications utilized to address the resident's psychiatric and behavioral needs: *Medroxyprogesterone Acetate 10 mg (milligrams) every evening for inappropriate sexual behaviors- 12/13/15 *Divalproex Sodium 500 mg one table tin the evening due to schizoaffective disorder *Clozapine 50 mg one tablet in the evening and 100 mg in the am for schizoaffective disorder</p> <p>Resident #3 was observed, on 03/08/16 at</p>		<p>Resident #3's medication was reviewed by the Behavior Committee and a recommendation was made to decrease his Clozapine from a total of 150 mg. per day to a total of 100mg. per day. The physician was notified on 4/6/16 that the resident continued to be lethargic at times and was drooling. There were no new orders obtained at that time. On 4/8/16 the facility notified the physician of the same issue – an order was received for Resident #3 to be seen by psych services on 4/24/16. The Nurse Consultant will in-service the nurses and DON on the requirement that physician is to be notified of pharmacy recommendations for medication adjustment as soon as the recommendations are received. If there is no response, or if the physician is unavailable, the on-call physician will be notified. If he is not available, the facility is to notify the Medical Director. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents receiving medications have the potential to be affected by this practice. If the DON or other IDT member finds that the physician has not been notified of a recommendation made by a provider, including pharmacy, she will make sure that the physician is notified of the</p>		

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	<p>10:30 A.M., in the dining room seated in his wheelchair with his head down and was visibly drooling onto his shirt front. The resident was greeting and attempted to speak but a large amount of saliva drooled out of his mouth and after briefly looking up, he immediately fell back to sleep.</p> <p>Resident #3 was observed on 03/10/16 at 11:45 A.M., seated in the dining room/lounge sleeping in his wheelchair while activities were being conducted. The resident was noted to be drooling and was very lethargic. The Activity Director was notified and she attempted to arouse the resident and then when she realized he was barely arousable she took him to his room where two nursing assistants tried to arouse him. The Director of Nursing was notified and eventually checked his blood sugar which was 262. All of the staff indicated the resident was found in this condition on an almost daily basis.</p> <p>Resident #3 was observed, on 03/11/2016 at 10:15 A.M., sleeping in the front of the facility by the front doors. The resident had his head down and eyes closed and was visibly drooling on his shirt front. There was a large soccer ball sized wet spot on his shirt. The resident was holding a glass of brown colored</p>		<p>recommendations as quickly as possible. Once that is taken care of, she will re-train the nurse(s) involved in regards to the facility policy for notification of the physician. She will render progressive discipline for continued noncompliance.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> The DON will review the 24 hour report, incident reports, pertinent progress notes, and any outside consultant reports that have been received at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. If any issues or concerns are identified, the DON will follow through as indicated in question #2. The DON/designee will audit the Pharmacy Recommendations for completion utilizing the Pharmacy Recommendation Audit tool with in 7 days of receipt from the pharmacy consultant and report her findings to the QA Committee Meeting. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the result of her daily review of physician orders and consultant recommendations to the weekly Standards of Care meeting and the monthly QA Committee</p>				

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	<p>liquids and almost spilt it on himself. He was awakened and with continued verbal cues and conversation, did wake up and spooned his liquid into his mouth but drooled and dribbled some down his chin and onto his shift front. He started coughing with the liquids initially but then fell back asleep.</p> <p>A pharmacy recommendation, dated 09/10/15, recommended the resident's psychotropic medication Depakote and Clozaril both utilized for schizoaffective disorder be evaluated for periods dose reductions. The recommendations were not addressed by the nurse practioner until 12/11/15, 3 months after the recommendations were made. On 12/11/15 the resident's antiipsychotic medication, Clozaril was reduced.</p> <p>During an interview, on 03/15/16 at 11:45 A.M., the Director of Nursing indicated she was aware of the delay. She indicated the psychiatric nurse practioner, at the time, was not able to visit timely due to a personal issue and she preferred to address, sign and make any changes when she was able to visit and evaluate the residents in person.</p> <p>3.1-25(j)</p>		<p>meeting for review and recommendations. Any recommendations made will be followed through by the DON and the results of those recommendations will be brought back to the next scheduled QA Committee meeting for review. This will continue on an on going basis. Date of Compliance: 4/15/16</p>		

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F 0441 SS=F Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>			

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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure proper infection control practices were implemented related to lack of hand washing after removal of gloves during a wound care for 1 of 4 residents (Resident #47) observed for wound care, open/expired respiratory equipment at bedside (Residents #11) improper sanitation of a glucometer after it was used for 2 of 2 diabetics (Resident #6, #27), visibly soiled areas on the medication cart used for all 33 residents in the facility, Foley catheter care for 2 of 2 residents (Resident #32) and oxygen tubing (Resident #11) lying on the floor for 2 of 2 residents.</p> <p>Findings include:</p> <p>1. On 3/9/16 a 9:22 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was admitted on 2/26/16 and re-admission on 3/4/16. The resident's diagnoses included but was not limited to: adult failure to thrive, chronic obstructive pulmonary disease, insulin dependent diabetic-uncontrolled, viral hepatitis and congestive heart failure</p> <p>During an observation of wound care, on</p>	F 0441	<p>It is the policy of this facility maintain an effective infection control program, including appropriate hand washing during treatment administration, appropriate storage of opened respiratory equipment and discarding of any equipment or supplies that are expired, appropriate sanitation of glucose blood meters, maintaining medication cart cleanliness, and observing appropriate Foley catheter care. 1. <u>What corrective action will be done by the facility?</u> Resident #47 and Resident #11 are no longer residents of this facility. The Nurse Consultant will in-service the DON on the proper treatment procedure, including hand washing when changing from dirty to clean gloves and before leaving a resident's room and will observe a return demonstration of the procedure by the DON. The DON and Nurse Consultant will in-service all the nurses on this same practice for treatment procedures, as well as proper storage of nebulizer equipment when not in use, use of appropriate PDS Sani-Cloths for cleaning and disinfection of blood glucose meters, maintaining cleanliness of the medication and treatment carts, proper storage of oxygen equipment when not in use, proper hand washing, and maintenance of Foley catheter</p>	04/15/2016			

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	<p>3/11/16 at 10:40 A.M., the Director of Nursing (DON) was observed cleansing a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) pressure ulcer for Resident #47. She wore gloves to remove the old dressing, then cleanse the wound with normal saline. She changed her gloves and marked the clean dressing with her pen. She placed the clean dressing on the resident. She was observed to take the soiled dressing from the trash to observe the old dressing. She removed her gloves into the trash, removed the trash bag, repositioned the curtains and bed side table. The DON walked out of room with soiled dressing in a trash bag, opened the door to the dirty linen closet, disposed of trash bag and walked across the hallway into another resident's to wash her hands.</p> <p>On 3/11/16 at 2:30 P.M., the DON provided a current policy titled "Dressing Change, Clean and Sterile", dated June 2004. The policy indicated "...PROCEDURE: 1. Provide privacy. 2. Place plastic bag near foot of bed to receive soiled dressing. 3. Open dressing pack. 4. Pour prescribed solution onto gauze to be used for cleaning. Put on gloves. 5. Remove soiled dressing and</p>		<p>bag and tubing to keep it off of the floor. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by these practices. If the DON, Administrator, or any member of the IDT observes or identifies any issue with hand washing, use of gloves, storage of equipment or any other infection control related problem, he/she will bring the staff member's attention to the noncompliance at that time and notify the DON if she is not already aware of the situation. The DON will follow through with re-training of the staff member involved and will observe a return demonstration of the technique to make sure that the staff member is knowledgeable of the appropriate procedure. When that is done, the DON may render written counseling based on the situation and outcome and continued noncompliance.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u>The DON/designee will audit for the proper storage of respiratory appliances and proper technique of handwashing and use of gloves during wound care 5 times a week for 30 days, twice a week for 30 days and weekly ongoing and report her findings to the monthly QA Committee Meeting for recommendations if</p>				

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	<p>discard in plastic bag. 6. Remove gloves and discard in plastic bag. 7. Wash hands. Put on clean gloves. 8. Cleanse wound with prescribed solution if ordered. 9. Apply prescribed medication if ordered. 10. Apply dressings and secure with tape. 11. Assist resident to comfortable position with call light with reach...."</p> <p>During an interview, on 3/14/16 at 10:45 A.M., the DON indicated she had messed up and forgot to wash her hands after removing her gloves during and after the procedure . She indicated she left the room without washing her hands because another resident was at the sink when she needed to use it to wash her hands.</p> <p>2. On 3/8/16 at 9:15 A.M., Resident #11's nebulizer mouthpiece and tubing were uncovered, and draped over his bedside table.</p> <p>3. On 3/9/16 at 7:58 A.M., LPN (Licensed Practical Nurse) #3 was observed using PDI Sani-hands wipes (brand name) (70 % alcohol) to cleanse a glucometer after she had obtained an accucheck (blood glucose test) on Resident #6. LPN #3 further indicated the facility's policy indicated she was to apply gloves and clean with wipe for 2 minutes. LPN #3 was observed cleansing the glucometer and setting a timer for 2</p>		<p>needed. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the result of her return demonstrations and audits to the weekly Standards of Care interdisciplinary meeting and to the monthly QA Committee meeting for further review and recommendations. When the time period for the QA audits and return demonstrations are finished, and if the facility has attained 100% compliance in each area, the QA Committee may decide to stop the written audits; however, the DON, Administrator, and IDT members will</p>				

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	<p>minutes. LPN #3 left the glucometer wrapped in wipe. Two other glucometers were observed in the cart, wrapped in a wipe.</p> <p>On 3/10/16 at 11:58 A.M., LPN #3 was observed using the PDI Sani-hands wipe to clean the glucometer after she obtained an accucheck test on Resident #27.</p> <p>On 3/10/16 at 2:25 P.M., the Director of Nursing (DON) provided a policy titled "Blood Glucose Testing & Disinfecting Procedure", dated August 2012 and indicated the policy was the one currently used by the facility. The policy indicated "... 3. Put gloves on and wipe the entire surface of the glucose meter to disinfect it with the Super Sani-Cloth wipe...4. Place the wipe around the meter as if wrapping it. Place the meter on clean surface and allow it to sit for 2 minutes...."</p> <p>On 3/10/16 at 2:45 P.M., the DON provided a User Manual for the Assure Platinum glucometer. The manual indicated "...Cleaning and disinfecting can be completed by using a commercially available EPA [Environmental Protection Agency] registered disinfectant or germicide wipe..." Another option the manual provided was "...To clean the outside of</p>			

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	<p>the blood glucose meter, use a lint-free dampened with soapy water or isopropyl alcohol (70-80%)...."</p> <p>During an interview, on 3/11/16 at 9:30 A.M., the DON indicated she was unaware of staff using Sani-hand wipes to disinfect the glucometers. She was observed going underneath the nurse's desk and obtaining a PDI Sani-Cloth container and taking the cloths to the nurse's medication cart. The DON told LPN # 3 she was to use the PDI Sani-Cloth.</p> <p>During an interview, on 3/11/16 at 9:40 A.M., LPN #3 indicated she was aware she was suppose to use the PDI Sani-Cloth, she used what was on the cart. She further indicated she had no wipes or clothes on the cart prior to the DON providing her with the PDI Sani-cloths.</p> <p>4. On 3/9/16 at 7:40 A.M., the buildings only Medication Cart had a brown substance along the seam of the cart's edge, the top of the cart had a brown dried substance on its surface.</p> <p>On 3/10/16 at 9:01 A.M., the Medication Cart had white power substance on the surface top and a small storage compartment on top of cart which</p>			

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	<p>contained medicine cups, spoon and straws had a dried brown spots on its surface and dust underneath it. The front of cart had a brown dried substance running down the front top drawer surface.</p> <p>On 3/10/16 at 10:03 A.M., the cart was observed to still have a dried brown drip down the front of the cart, a white power substance on top of the cart and the small compartment had small brown dried spots</p> <p>During an interview, on 3/11/16 at 2:44 P.M., LPN #3 and LPN#4 confirmed the medication cart had a dried brown substance on the front of the cart and the top of the cart was dirty with dust and a white powder substance. Both LPN's agreed the small compartment with spoons, straws etc was visually dirty. LPN #3 indicated the cart is usually cleansed each shift.</p> <p>5. On 3/10/16 from 2:00 P.M. to 2:30 P.M., an environmental tour was conducted with the Maintenance Director, the Housekeeping Supervisor, and the Administrator, during which the following was observed:</p> <p>At 2:10 P.M., Resident Room 5 bed 2, a nebulizer machine was observed on the</p>			

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	<p>resident's bedside stand. The nebulizer tubing was plugged into the machine and part of the tubing and the hand held mouthpiece was observed in the trash can beside the resident's bed.</p> <p>At 2:22 P.M., Resident Room 13 bed 1, a nebulizer machine was observed on the resident's bedside stand the tubing was draped across the machine it was not dated and was uncovered.</p> <p>At 2:30 P.M., Resident Room 18 bed 2, a nebulizer machine was observed on the resident's bedside stand. The nebulizer tubing and mouthpiece were draped across the machine, the tubing and mouthpiece was not dated and was uncovered.</p> <p>During an interview, on 3/10/16 at 2:40 P.M., the Administrator indicated the tubing should not be stored like that.</p> <p>On 3/10/16 at 4:30 P.M., RN (Registered Nurse) #20 provided a policy titled "Hand Held Nebulizer," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...B. Hand Held Nebulizer 1. Clean between treatments and place in a bag for storage. 2. Use single resident nebulizer. 3. Change each nebulizer at least once a week or according to facilities specific</p>			

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	<p>guidelines...."6. On 3/9/2016 at 2:35 P.M., Resident #37 was observed to drop a bottle of orange soda. The staff was observed to pick up the soda from the floor and give it back to the resident.</p> <p>On 3/10/2016 at 10:05 A.M., Resident #32 was sitting in dining room with his nasal cannula lying on the floor and wrapped around his wheelchair wheels.</p> <p>On 3/11/2016 at 1:44 P.M., Resident #32 was observed sitting in his wheelchair, in the dining room with his catheter bag and tubing dragging the floor.</p> <p>On 3/11/2016 at 2:20 P.M., CNA (Certified Nursing Assistant) was observed to pick up Resident #32s catheter bag and place in back into his dignity bag wearing gloves. She removed her gloves. She than proceeded another resident in her wheelchair. She was not observed to wash her hands following care for Resident #32 and proceeding care for another resident.</p> <p>On 3/14/2016 at 2:06 P.M., Resident #32 was observed sitting in his wheelchair, in his room with his catheter tubing dragging the floor.</p> <p>On 3/15/2016 at 10:51 A.M., Resident #32 was observed sitting in his</p>			

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F 0465 SS=D Bldg. 00	<p>wheelchair in the dining room with his catheter dragging on the floor.</p> <p>On 3/15/2016 at 12:16 P.M., Resident #11s nebulizer mouth piece was observed to be sitting on his bedside table uncovered.</p> <p>On 3/15/2016 at 12:21 P.M., Resident #32s nebulizer mask was observed sitting on the residents bedside table uncovered.</p> <p>On 3/11/16 at 12:10 P.M., the DON (director of nursing) provided a policy titled "Catheter Care - General Information," dated June 2004 and indicated this was the policy currently used by the facility. The policy indicated "...10. Transferring resident: c. Never allow bag to touch floor...."</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and clean</p>	F 0465	It is the policy of the facility to provide a safe,,functional,	04/15/2016			

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	<p>environment related to, scrapes and gouges in the wall of a resident room and around the doorway of a community resident restroom. This had the potential to affect 1 of 33 residents and 1 of 4 community resident restrooms located in the facility.</p> <p>Finding includes:</p> <p>On 3/10/16 from 2:00 P.M. to 2:30 P.M., an environmental tour was conducted with the Maintenance Director, the Housekeeping Supervisor, and the Administrator, during which the following was observed:</p> <p>At 2:10 P.M., Resident Room 5 bed 2 was observed to have scrapes and gouges in the wall by the head of the resident's bed. The area was approximately 6 inches in width and 5 inches in length, the scrapes were deep enough to expose the drywall underneath.</p> <p>During an interview, on 3/10/16 at 2:15 P.M., the Maintenance Director indicated the scraped area at the head of the bed looked like it had just occurred and further indicated he would repair the area as soon as possible.</p> <p>At 2:30 P.M., scrapes and gouges were observed on the door frame surrounding</p>		<p>sanitary, and comfortable environment for residents, staff and the public. <u>What corrective action will be done by the facility?</u> Resident's room #5 bed#2 and the door frame of resident restroom #4 has been repaired. An audit was immediately completed and all walls and door frames were repaired. <u>How Will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected. Wall and door frame damage has been added to the Preventative Maintenance Daily Log Sheets. Maintenance will make daily rounds documenting any wall and door frame damage on his Preventative Maintenance daily log sheet. Housekeeping will observe each room daily while cleaning and immediately fill out a maintenance repair slip, for any damage to walls and door frames both in resident rooms, hallways and bathrooms. <u>What measures will be put into place to ensure this practice does not recur?</u> All managers will check for compliance during their daily guardian angel rounds, and they will bring any observations of needed repair sto the IDT morning management meetings that are held at least 5 days a week. In addition, needed repairs will be filled out on a repair maintenance slip. One copy will be given to administrator and the</p>	

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F 0490 SS=F Bldg. 00	<p>the community resident restroom #4.</p> <p>During an interview, on 3/10/16 at 2:40 P.M., the Housekeeping Supervisor indicated it is very hard to keep all of the doorways painted due to the wheelchair wheels constantly scraping the paint off. She further indicated she does a walk through of all the resident rooms weekly, and if she sees a concern she writes it down on a Maintenance work order. She indicated she places the work order in the Maintenance Directors mailbox so he can then prioritize what he needs to work on first.</p> <p>3.1-19(f)</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interviews, the facility failed to administer the facility in a manner to ensure management implemented the abuse policy and procedures to protect residents which resulted in substandard</p>	F 0490	<p>other copy given to maintenance. Upon repair maintenance will turn his slip into the administrator when completed. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Director of Nursing or Administrator will bring the results of the Guardian Angel rounds, Maintenance daily log sheets and Maintenance request forms to the monthly QA for review. QA will review for 3 months. Once 100% compliance is achieved the Quality Assurance committee may decide to stop the checking. The DON, other IDT members, and Administrator will continue to observe to ensure compliance as part of their routine rounds done during each one's tour of duty. All systemic changes will be completed b y 4-15-16</p> <p>It is the policy of this facility to ensure that it is managed appropriately to implement the abuse policy and procedure, as well as making sure the residents are protected. This includes ensuring that occurrences of</p>	04/15/2016			

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	<p>quality of care. This deficient practice had the potential to affect 33 of 33 residents in the facility.</p> <p>Findings include:</p> <p>Based on specific information denoted in a complaint, residents and staff were interviewed regarding abuse, including an allegation of sexual abuse involving Resident #1 and a certified nursing staff member.</p> <p>During an interview, on 03/09/16 at 8:59 A.M., LPN #50 indicated she had overheard staff conversing about Resident #1 inappropriately touching CNA # 51. The nurse indicated she then reported the incident to the Administrator and Director of Nursing to make sure they were aware of the incident. She indicated she had reported the allegation approximately a month ago, as soon as she overheard other staff talking about the incident.</p> <p>During an interview with the Activity Director, conducted on 03/09/16 at 1:45 P.M. she indicated she was aware of "hearsay" regarding Resident #1 and "second shift CNAs." She indicated she had heard Resident #1 had his hands down the pants of a CNA between her pants and underwear and was "rubbing"</p>		<p>verbal, physical, or sexual abuse, including staff-to-resident situations, are reported immediately to the Administrator, investigated, and reported timely to the state agency. 1. <u>What corrective action will be done by the facility?</u> The Administrator did suspend the staff involved in the allegation of abuse when notified during survey of the occurrence once again. She also notified the state agency of the occurrence and followed through with a 5-day follow up as per state guidelines. Since that time, the Administrator has been replaced. Resident G has had his care plan reviewed and updated to be reflective of his current behaviors and interventions. The current Administrator, DON, and Nurse Consultant will re-train all staff regarding the facility's Standards of Conduct, which outlines the expectation that an allegation of any type of abuse or neglect, including sexual abuse, must be reported immediately to the Administrator. As part of her orientation to the facility, the interim Administrator has been oriented to the facility policy regarding the prompt reporting of allegations of abuse or neglect to the state agency, and the requirement for starting an investigation immediately upon receiving an allegation of abuse or neglect. 2. <u>How will the facility identify other residents having the potential to be affected by the</u></p>				

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	<p>her. She indicated she had heard about the incident about a month ago and she would have reported it to the Administrator but she knew for a fact another staff member, who also heard about the incident at the same time, had immediately reported the allegation to the Administrator. She indicated she had never witnessed Resident #1 touching staff inappropriately herself.</p> <p>During an interview, on 03/10/16 at 2:16 P.M. with CNA #52, she indicated she had reported an incident she considered sexually inappropriate between Resident #1 and CNA #53 to the Administrator about a month ago. CNA #52 indicated she had entered Resident #1's room, at approximately 5:00 A.M., to assist CNA #53 with resident care and she witnessed Resident #1 with his hands down the pants of CNA #53. She indicated CNA #53 was allowing Resident #1 to have his hand down her pants. She indicated she interrupted the activity and Resident #1 did remove his hand. CNA #53 then tried to make up an excuse to CNA #52 regarding why Resident #1's hand was down inside her outside pants. CNA #52 indicated she felt the incident was not accidental and she reported the incident to the Administrator the same morning when the day shift arrived in the building. CNA #52 indicated she was not asked for</p>		<p><u>same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice. The DON will review the 24 hour report, incident reports, and pertinent progress notes at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed including those that demonstrate issues with resident behaviors that are affecting other residents or staff. Recommendations made by the team will be followed up by the designated team member(s). Any changes to the behavior log and care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as needed and will indicate a change in interventions or behavior plan on the 24 hour report form to make sure that communication is extended to other shifts. 3. <u>What</u></p>		

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	<p>further information regarding the incident she had witnessed and reported until 03/09/16.</p> <p>During an interview with the Administrator regarding the facility's Abuse prohibition policies and procedures, conducted on 03/14/16 at 10:45 A.M. , she indicated she had been informed of the concern regarding Resident #1 and CNA #53 on 02/02/16 by CNA #52. She indicated she had "looked into it" but had not formally investigated the concern as an allegation of possible abuse because she had initially been told the resident's hand was on the CNAs "butt." She indicated when it had again been brought to her attention during the survey process, she had initiated an investigation and had reported the allegation to the Department of Health on 03/09/16.</p> <p>3.1-13(q)</p>		<p><u>measures will be put into place to ensure this practice does not recur?</u> In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director will monitor residents' environment and any indication of discomfort or unease with other residents or staff as part of their frequent rounds that occur during each tour of duty. Any concern expressed regarding any resident will be documented on a resident concern form and will be brought to the attention of the Administrator immediately, if she is not the one who has received the concern firsthand. Once the staff and the Administrator have made sure that safety is assured for all residents involved, the Administrator will bring the interdisciplinary team and related documentation together to discuss the concern expressed by the resident. If the concern is alleged abuse, the staff identified as being involved will be suspended immediately. The Administrator will also notify the Indiana State Board of Health if the concern meets the guidelines as a "reportable incident" and will begin an investigation. She will also notify ISDH of the results of her investigation into the incident as required by Indiana guidelines. The attending physician and family/legal representative will be notified of the occurrence – if directed by the attending</p>		

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			<p>physician, the psychologist will also be notified. The facility will follow through on the physician's recommendations and will document the results. At least twice a month, the Nurse Consultant will review any instances of physical or verbal abuse that have occurred and been reported to the state agency since her prior visit to make sure that reporting and follow up have occurred as required. If she identifies any issues, she will review them with the Administrator and other involved staff and will re-train them in regards to the facility policy and the state/federal regulations.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator and Social Services Director will report any occurrences of resident abuse and other ongoing behaviors, along with the results of specific interventions designed to prevent the abuse situation, to the monthly QA Committee meeting for further review and recommendations. The Administrator will also report any recommendations made by the Nurse Consultant's audits of abuse incidents and subsequent reports. Recommendations will be followed up by the designated person who will report the results of those recommendations at the next Committee meeting. This will</p>	

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F 0514 SS=E Bldg. 00	<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 interview and record review, the facility failed to ensure staff had access to needed clinical records related to wound assessments and dialysis information/communication for 3 of 33 residents. (Resident #9, #11 and "G")</p> <p>Finding includes:</p> <p>During a record review on 3/9/2016 at 2:45 P.M., DON (Director of Nursing) indicated the facility does not have any documentation related to communication with the dialysis center and unable to locate any orders to monitor the residents dialysis access site.</p> <p>During an interview on 3/10/2016 at</p>	F 0514	<p>continue on an ongoing basis. Date of Compliance: 4/15/16</p> <p>It is the policy of this facility to ensure that staff has access to needed clinical records for all residents including those related to wound assessments and dialysis information/communication. 1. <u>What corrective action will be done by the facility?</u> Resident #11 is no longer at the facility and there are no other residents requiring dialysis at this time. However, the nurses will be in-serviced in the use of the post-dialysis documentation form, which is to be used to assess a resident's status upon the return from a dialysis visit. This requirement will be reviewed with them again when a dialysis resident is admitted once to the facility once again.</p>	04/15/2016	

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	<p>10:45 A.M., LPN (Licensed Practical Nurse) #3 indicated the facility did not have a form of communication related to dialysis services or assessments for Resident #11. She further indicated that there was no form of documentation she could access at the facility to inform her of the assessments performed at the dialysis center for Resident #11.</p> <p>On 3/14/2016 at 11:36 A.M., the Coporate Nurse provided the policy titled "Change of Condition - ICF/MR [Intermediate Care Facility/Mentally Retarded]" dated March 9,2005, and indicated this was the policy currently used by the facility. The policy indicated "...Documentation in the nurses' notes is required each shift on any resident who experiences a problem, demonstrates a symptom or any change of status. Documentation must continue each shift for at least 24 hours, and usually 72 hours, after the problem is identified, then daily until the problem is noted as resolved...."</p> <p>During an interview on 3/11/2016 at 9:38 A.M., the social service director indicated that she was unaware that Resident "G" was having any inappropriate behaviors. She further indicated that the behaviors listed in the behavior log were the only behaviors Resident "G" experienced.</p>		<p>Additionally, the DON and Administrator have been in-serviced by the Nurse Consultant regarding what information will be needed from dialysis providers on a routine basis before confirming them as providers for facility residents in the future. The DON will talk with the family of Resident G regarding the possibility of obtaining mental health counseling for him and to assist staff with a better understanding of his behaviors and ways to redirect those behaviors when they occur. The DON asked the family for consent for this counseling shortly after the resident was admitted, and the family declined at that time. The DON will document the family's response to her request in the resident's chart. All staff will be in-serviced on the behavior management system, including documentation and the use of the behavior log for all behaviors being observed and tracked for each resident. The staff will also be trained to utilize the Social Services Referral form to communicate resident needs to the Social Services Director, including interventions that have not been successful in redirecting are resident's behavior. Additional outside consultation will be scheduled for the Social Services Director to clarify any questions that she may have regarding the facility's</p>		

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	<p>During an interview on 3/11/2016 at 11:24 A.M., the DON (Director of Nursing) indicated Resident #9 should have a care plan addressing her refusal of any type of treatment to her right arm. She indicted Resident #9 was unable to move her right arm and the MDS (Minimum Data Set) should reflect this, however it does not. She further indicated Resident #9s' care plan is not reflective of the residents needs.</p> <p>3.1-50(a)(1) 3.1-50(a)(3)</p>		<p>behavior management system, and to provide an additional resource for identifying specific resident behaviors& approaches. In addition, the interdisciplinary team will be re-trained by the nurse consultant on the importance of updating resident's care plans as behaviors are identified, as behaviors change, and as interventions are added, revised, and deleted. Resident #9's care plan has been updated to reflect her consistent choice not to wear a splint on her right arm or to have ROM to her upper body. There will be a modification done to the 3/9/16 MDS to accurately reflect the fact that she is unable to move her right arm. Nursing staff will be in-serviced on the need for splints and ROM for residents who have contractures or are otherwise unable to move one of their extremities.They will also be in-serviced on informing the DON or charge nurse if a resident refuses the use of these other devices/modalities. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by these practices. If any member of the IDT becomes aware of dialysis residents without documentation from the dialysis center or from the nurse on duty when the resident returns to the facility; lack of splint or</p>		

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			<p>ROM use for residents with contractures; inaccurate MDS documentation; or lack of assessment of behaviors or communication of specific interventions when dealing with behaviors, he/she will report the issue directly to the Administrator and DON, who will begin an investigation immediately to resolve the issue as quickly as possible. Once the resident situation is taken care of, the DON, Administrator, or other involved IDT member will re-train the staff involved in the identified issue. Progressive written counseling will be rendered for continued noncompliance.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> If the DON or other IDT member finds that an assessment has not been completed or followed up by staff as necessary, or, a lack of communication has occurred with a resident receiving dialysis, they will notify the DON (if she is not already aware) who will make sure that the assessment is done as quickly as possible, with the results followed through as needed and reflected on the resident's care plan. In the case of needed communication, the DON will follow through to make sure that the dialysis center sends pertinent information as a follow up to the resident's dialysis visit. If the DON or other IDT member finds that a resident has</p>	

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			a contracture or other lack of mobility in one of his/her extremities and does not have a splint or is not receiving treatment, such as ROM, the DON will talk with the resident and notify the therapy provider for evaluation of the resident's condition. If the resident declines the use of a splint or does not want to receive ROM or other type of treatment, that choice will be documented in the resident's record and in the resident's care plan. The Social Service Director and other interdisciplinary members of the Behavior Committee will audit behavior logs to make sure that listed behaviors on the log are current and that all interventions are current, including any that have been developed as per the recommendation of the mental health providers. Once all logs are updated, the residents' care plans and CNA assignment sheets will be updated, as well. All members of the IDT will observe the staff's attempts at redirecting behaviors for evidence that each staff person involved is following the interventions care planned for that resident and behavior, and that he/she has done accurate & complete documentation of the behavior on the behavior log. If any staff member is observed not to follow the care planned interventions for a resident who is experiencing a behavior, the Social Services	

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			<p>Director and/or IDT member will intervene immediately to make sure that the resident's behavior is managed according to the planned interventions. Once the resident's behavior has subsided and the resident's safety is assured, the Social Services Director and/or IDT member will re-train the staff involved regarding the behavior log, the care plan, and its use. The SSD will bring the behavior log to the morning management meeting for review by the IDT and any recommendations documented in the behavior plan and the resident's care plan. In all of these areas mentioned in the 2567, the DON and Administrator will make sure that any identified issue will be addressed as quickly as possible for the resident's health and safety. Once that is assured, the staff members involved in the issue itself will receive re-training and possible written counseling, depending on the situation itself. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or other designated members of the IDT will bring the result of their audits to the weekly Standards of Care meeting and the monthly QA Committee meeting for review and recommendations. Any recommendations made will be followed through by the assigned member of the IDT and the</p>	

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			results of those recommendations will be brought back to the next scheduled QA Committee meeting for review. When the written audits have shown 100% compliance, the QA Committee may decide to stop them; however, the monitoring by the IDT members will continue as indicated on an ongoing basis. Date of Compliance: 4/15/16		